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The prevalence and experiences of intimate partner violence among Saudi women in the UK

The Prevalence and Experiences of Intimate Partner Violence among Saudi Women in the UK

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بسم الله الرحمن الرحيم
In the name of God the entirely
Merciful, the especially Merciful

"ومااكرمهن الا كريم ومااهانهن الا لئيم"

"خياركم خيار لإهله"

"It is the generous (in character) who is good to women, and it is the wicked who insults them"

"The most perfect believers are the best in conduct. And the best of you are those who are best to their wives"

Prophet Mohammad
Peace be upon him

Abstract

Background: Intimate partner violence (IPV) against women is a substantial public health problem, a serious human rights violation, and a major factor contributing to women's morbidity and mortality worldwide. Little is known about the prevalence and experiences of IPV among Saudi women.

Aim and objectives: the aim is to investigate IPV among Saudi women living in the UK. This aim was fulfilled through by four objectives: 1) The translation of the Composite Abuse Scale (CAS) into Arabic and adaptation of the SF-36 questionnaire, 2) The measurement of different types and severity of IPV, 3) The measurement of any associations between IPV, women health status, and their socio-demographic profiles, 4) The exploration of women's subjective experiences of IPV.

Methods: Mixed methods were used. The first study involved initial forward translation of the CAS, experts' panel discussion, focus groups discussions, and back translation. The second study was a self-reported survey posted to a stratified random sample of Saudi women in the UK (n=718). Response rate was 45%. The third study included in-depth semi-structured interviews with 20 women to explore their IPV experiences.

Results: Prevalence of severe combined abuse was 19%, emotional abuse and/or harassment was 11%, physical abuse, emotional abuse and/or harassment was 3%, and physical abuse alone was 2%. Logistic regression analysis showed significant associations between severe combined IPV with several items of the SF-36 health survey and a few socio-demographic profiles. Interviews explored diverse experiences, and beliefs of IPV in the contexts of their religion, socio-cultural, economic-political, and health profiles.

Conclusion and implications: IPV is prevailing among Saudi women in the UK with impacts on their well-being. This calls for further cohort longitudinal studies to investigate IPV among Saudi with a multi-dimensional approach considering the dynamics and intersections of socio-cultural, religious, economic-political, and health status factors, to measure its impacts and to plan needed resources.

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This thesis is dedicated to my brother Abdulaziz. I cannot find words to express his love and support. I dedicated this thesis also to my daughter Raghda, who has always stood by me and believed that I could do it. I also dedicated my thesis to Dr Abdulrahman Mohamed Salih, who was one of the expert committee that commented on the translation of the CAS, but sadly left before seeing the result of his effort. My sincere prayers to Allah to keep your soul in heaven.

Declaration

I declare that the work in this dissertation was carried out in accordance with the requirements of the University's regulations and Code of Practice for Research Degree Programmes and that it has not been submitted for any other academic award. Except where indicated by specific reference in the text, the work is the candidate's own work. Work done in collaboration with, or with assistance of, others, is indicated as such. Any views expressed in the dissertation are those of the author.

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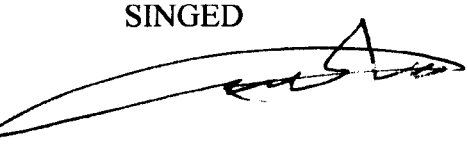

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Supervisors: Professor. Gene. Feder and Dr. Jeremy Horwood

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Chapter 1. Introduction

1.1 Background

Intimate partner violence (IPV) against women is a serious human rights violation, a substantial public health problem and a significant factor contributing to women's morbidity and mortality worldwide [1]. Its health burden is significantly greater than any other risk factors of major chronic health diseases, such as smoking and obesity [2].

As far as is currently known, violence against women knows no racial, ethnic, or class boundaries; it is prevalent in the lives of women across any socio-cultural grouping [3-4]. In the past decade, there has been an increasing interest in the problem of IPV among researchers from various specialties, including health professionals, social scientists, and politicians. However, there is still a lot to know about the experiences and characteristics of such violence, partly because it is a complex problem that needs multi-facet efforts to understand its epidemiology and the consequences it may cause.

Longitudinal population health studies have found that the highest risk factor in determining the physical health of women under the age of 45 was whether they had experienced IPV [5-6]. Violence against women by their partners can reduce women's energy, and may compromise their physical and mental health, and erode their self-esteem [7]. In addition, it can increase women's long-term risk of a number of other health problems, such as mental health disorders, drug and alcohol misuse, and depression [8]. Furthermore, women with a history of physical or sexual abuse are at increased risk of unintended pregnancy, sexually transmitted diseases and abortions [9]. Globally, women aged 15 - 44 are more likely to be maimed or die because of male violence than through cancer, malaria, traffic accidents and war all together [10].

In the United States, the annual cost of IPV has been estimated to be approximately $5.8 billion, and £23 million in the UK [11]. Recently, in the year 2008, the cost of domestic violence was estimated at £ 15,730 million in the UK [12]. Economic costs include the time off work due to injuries sustained because of violence, losses to productivity because of stress and reduced performance, and the costs of providing health care and other services, increased absenteeism, decreased productivity and lower earnings.

In Arab and Islamic countries, domestic violence is not yet considered a major concern despite its increasing proportions and adverse consequences [13]. This response to violence stems from attitudes that it is a private matter, which should be discussed between partners only and, usually, a justifiable response to supposed misbehaviour on the part of the wife. Douki and colleagues believed that selective excerpts from the Qur'an are used to justify that men who beat their wives are following God's commandments, although this was disputed by other scholars [13]. They also thought that these religious justifications, plus the importance of preserving the honour of the family, lead abusers, victims, police and health care professionals to join in a conspiracy of silence rather than disclosing these offences. However, they suggested that unbiased reading of the Koran shows that wife abuse, like genital mutilation and honour killing, are a result of culture rather than religion.

Worldwide, policy efforts addressing IPV have been focused on providing community-based support for victims, creating legal remedies, and reframing political issues. Until recently, violence-related research was largely outside the domain of health and healthcare in most countries. In the last 20 years, a change in the perception of IPV as a health concern has risen, encouraging healthcare workers and researchers to investigate the subject and its consequences from a health perspective in, at least, some countries [14-15].

From a primary health care point of view, diagnosing a patient's difficulties and distinguishing them from a problem list which may be presented by some patients,

is a duty of care for general practitioners (GPs) in the UK, as well, as in Saudi Arabia. This is particularly true in women, who present to primary care frequently with unexplained, and difficult to diagnose symptoms and signs. As a GP, I have a special interest in the field of IPV against women and its effect on their health and well-being. I became also concerned with many aspects in my routine professional practice, due to the frequent unexplained visits of some women to my practice in Saudi Arabia. Hence, this thesis commenced to measure IPV and explore of Saudi women in the UK.

1.2 Definition of IPV

Researching IPV against women is challenging for several reasons. One important reason involves the safety issue of the participants and researchers. Other reasons include the various definitions of IPV that are used by researchers, a lack of clarity about which specific behaviours constitute IPV, and the differences in research methodologies, particularly across different cultural communities [16]. Despite the large volume of literature generated over the last decade, there are still debates within the literature about how to define IPV [17]. This definition problem has been raised at the theoretical and pragmatic levels in various legal, governmental, social, cultural, and health care settings in several countries. How one defines IPV determines how one measures it, which in turn affects what conclusions can be drawn about the prevalence, patterns, gender differences, and health consequences of IPV [18].

In many areas of the world, the term 'domestic violence' might refer to the abuse of women by current or former male intimate partner [19]. It may include not only the violence by an intimate partner but by other family members. For example, in Latin America, where women are brought up in patriarchal familial organization which tend to promote passivity and dependency domestic violence often refers to any violence that occurs in the house, including violence against children and the elderly [20-21]. Similarly, in English speaking countries, domestic violence refers to the abuse by a partner [22]. Another aspect to be taken into consideration in the debate of defining IPV is the trans-cultural applicability of definitions, and this

aspect arises in the context of international studies or those conducted in immigrant populations [23].

The centre for Disease Control (CDC) and the World Health Organization (WHO) have recommended the use of the term 'intimate partner violence' when referring to violence between intimate partners [24-25]. The definition of IPV developed by CDC is:

> *physical and/or sexual violence (use of physical force) or threat of such violence, or psychological/ emotional abuse and/or coercive tactics when there has been prior physical and/or sexual violence, between persons who are spouses or non marital partners (dating, boyfriend-girlfriend) or former spouses or non marital partners* [26].

The WHO defines IPV as:

> *any behaviour within an intimate relationship that caused physical, psychological or sexual harm to those in the relationship and includes physical aggression, psychological abuse, forced intercourse and other forms of sexual coercion, and various controlling behaviours [27].*

The CDC definition includes only emotional abuse when it is combined with either physical or sexual violence, whilst WHO includes psychological abuse by itself.

The United Nations (UN) defines violence against women as:

> *Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life [28].*

Many experts have been involved in international efforts to address these controversies in developing standardized definitions of IPV, however, they are still missing the language and cultural contexts which might define IPV in various manner, and in particular among immigrant abused women [29]. For example: isolation of women by limiting external contacts, not allowing English-language

training, threatening deportation, and economic abuse. However, cultural contingency—the concept that the definition of IPV will vary from culture to culture and sometimes even within a culture—suggests these definitions and typologies may not be adequate when applied to diverse cultural groups [30]. This generally is true in Arab cultures, particularly in Saudi Arabia, where religious and tribal values define and shape the relationship between partners, giving little choice to individuals or couples to modify or change such values or create their own relationships. Therefore, in this thesis, I cannot be sure whether the definition I adopted is adequate to address the prevalence of IPV among Saudi women living in the UK. Especially, in the present time, there is a lack of in-depth qualitative or quantitative studies conducted among Saudi population, which could have laid the ground in developing a culturally specific definition of IPV. Furthermore, exploring understanding and probably the definition of IPV Saudi women might held would shed light on the future development of a culturally sensitive definition of IPV.

In my thesis, the operational definition of IPV I use includes abusive physical, sexual, or emotional acts between partners. This includes also combinations of these types and the severity of each to reflect possibly the reality of the experiences of such violence between partners. Since it is the first population study among Saudi women, I have approached such problems by trying to capture not only the prevalence of IPV, but also the experiences and issues surrounding its occurrence. However, the instrument selected in any research, including my research, to measure IPV pragmatically helped in providing the spectrum of cases defined as abused or not (see Table 1-1 for detailed instruments).

1.3 Prevalence of IPV

The various definitions of IPV have resulted in the development of different measurement scales [23]. These scales in turn have resulted in a great variability in its reported prevalence. Furthermore, other variables that are associated with violence such as socioeconomic factors, race, time of abuse (as in pregnancy), and so on, have played a role in heterogeneity of the estimate within and between

countries. Reported estimates of abuse are highly sensitive to the particular definitions used, the way in which questions are asked, the degree of privacy in interviews and the nature of the population being studied [31].

In a multi-country population-based survey conducted by WHO in 15 cities in ten countries, the lifetime prevalence of physical or sexual partner violence, or both, varied from 15% to 71%, with two countries having a prevalence of less than 25%, seven countries between 25% and 50%, and six countries between 50% and 75%. Between 4% and 54% of respondents reported physical or sexual partner violence, or both, in the past year [32]. This showed that even using the same tool (invented by WHO) to measure IPV resulted in differences in the rate of prevalence in various countries.

The recent British Crime Survey (BCS) on partner violence showed 22% of men, and 33% of women had experienced abuse from a partner since the age of 16, but the physical and emotional impacts on females were significantly greater than on male victims [33]. Moreover, in a report issued by the Centre for Communications Programs, at Johns Hopkins University, it was shown that 10–69% of women worldwide, and 18–58% of women in Europe, reported having suffered physical abuse by their partners at some point in their life [34]. These figures revealed the worldwide variability of IPV prevalence.

In my recent systematic review, the worldwide prevalence of lifetime violence against women, measured with a range of instruments, varies from 1.9% in some communities in Washington, US, to 70% in some communities in Hispanic Latinos in Southeast US [35]. The percentage of women who had been assaulted by a partner in the previous 12 months varied from 3% among groups of women in Australia, Canada, and the United States, to 27% of ever-partnered women in Nicaragua, 38% of currently married women in the Republic of Korea, and 52% of currently married Palestinian women in the West Bank and Gaza Strip. For many of these women, physical assault was not an isolated event but part of a continuing pattern of abusive behaviour. (For more details about prevalence studies, see Chapter 2 of the literature review).

1.4 IPV Measurement

The prevalence of IPV is influenced by a society's views of IPV, public problem-solving discourse, the role and status of women, the role of religious and political leadership, economic conditions, general levels of safety, and social stability [36]. Due to the definitional difficulties discussed above, efforts to measure the prevalence of IPV has produced a variety of measurement instruments [37]. It is also difficult to determine accurately which type and how frequently acts of violence need to occur before researchers classify them as 'abuse' rather than as part of ordinary couples' conflict interactions. This depends on the situations in which women find themselves involved in, their culture, social relations, and perceptions. It has been argued that there are three forms of violence against women [38]. Johnson, for example, claims that some families suffer from occasional outbursts of violence during conflicts from either husbands or wives (common couple violence), while other families are terrorized by systematic male violence (patriarchal terrorism), or both (as the third type of violence) [38]. Similarly, Berkowitz outline two types of violence 'expressive' and 'instrumental' that occur in relationships. Expressive violence occurs because of escalating conflict between partners in which it is easy to identify the precipitating event, and both couples are involved in the escalation. Instrumental violence is the deliberate use of violence as a tool to punish or control the behaviour of the partner [39].

In the field of IPV, when deciding which measure to use, one should assess the type of scoring that the instrument is based on (whether scores can be easily analyzed in relation to other variables), the reliability, validity, appropriateness of the instrument for the study population, and the research question to be addressed [25]. Different tools have been used to measure various types of violence: physical, sexual, and psychological. Although, qualitative studies suggest that some women find the psychological abuse and degradation even more intolerable than the physical violence, international studies have frequently concentrated on physical violence because it is easier to conceptualize and measure than other types of abuse [40]. Furthermore, some women might normalize IPV, especially

non-physical abuse due to the influence of their societal or cultural gender inequality in roles and expectations. Subsequently, this might contribute to their silence and continuous pattern of IPV.

Researchers have used several instruments for measuring violence against women (Table1-1) [41]. These instruments have been designed using different theoretical frameworks. For example, the Conflict Tactics Scale (CTS) has been based on conflict theory that assumes that conflict is an inevitable part of all human associations, whereas violence as a tactic to deal with conflict is not [42]. The CTS measures verbal and physical aggression and has been used as the gold standard tool for measuring violence against women in some countries [43]. It was developed to measure conflict tactics between partners, in contrast to coercive tactics, and focuses mainly on physical violence as the main form of violence. With this method of measuring conflict tactics, violence, as well as rationale discussion and dialogue, and verbal aggression, is seen as a method to resolve conflicts within the family. The CTS does not elicit the intensity, context, and consequences of the actions. However, the CTS2 (revised CTS) includes scales to measure an additional type of partner abuse (sexual coercion) and a consequence (physical injury from assaults by a partner). Additionally, the CTS2 wording was revised to increase its specificity and clarity [42]. This modification of the CTS and simplified format facilitated its use as a self-administered questionnaire, and hence, made it more widely used in the US and North America.

On the other hand, the abusive behaviour inventory (ABI) reflects the feminist perspective where physical violence is conceptualized as the result of power and control that the abuser has on the victim [44]. The Psychological Maltreatment of Women Inventory (PMWI) developed with a focus solely on psychological abuse [45]. Other tools, like the Measure of Wife Abuse (MWA), the Index of Spouse Abuse (ISA), the Abuse Behaviour Inventory (ABI), and the Abusive Risk Inventory for Women (ARI), were developed, in the US, to measure the different range of abuse but have only been validated on small samples [40, 46-47].

The majority of the abuse instruments have been modified, especially, if the scale was developed in certain cultures, and researchers need to use it in another culture. For example, the WHO instrument (interview-based questionnaire) that was built on the tradition of the Conflict Tactics Scale was modified and translated into various languages in order to be applicable in different cultures. Furthermore, various IPV instruments have been used in both clinical and population studies. Hence, the outcomes of these studies might provide different measurements of IPV and lead to diverse implications in both settings (clinical vs. population). Furthermore, there are limitations of these measures, which have an impact on the precision of the prevalence of IPV and subsequently on policy implications and resources needed to help abused women.

In my thesis, I decided to use the Composite abuse scale (CAS) as this is a comprehensive self-reported questionnaire, developed in English, in Australia, in the last eight years to measure specifically intimate partner violence [48]. It has the advantages of being validated in three large samples of Australian populations, being able not only to measure the prevalence of violence but also to classify women according to the severity and type of abuse. It is a reliable tool to measure a broad definition of a multi-dimensional abuse against women [49]. In addition, the CAS has demonstrated face validity (suitability), content validity (actually measures what it is expected to measure), criterion validity (demonstration of the test effectiveness in predicting the criterion of a construct), and construct validity (the degree to which a test measures the concept intended to measure) [40]. Its items represented acts of physical, emotional, and sexual abuse, with elements of severity within each dimension, and these items were selected from four scales: CTS, PMWI, ISA, and MWA. This multi-criteria make it an appropriate comprehensive measure to use in a population, like Saudi women, where there have been no previous systematic efforts to understand or explore the problem of IPV. A summary of the characteristics of IPV scales is contained in Table 1-1.

Table 1-1: Summary of IPV tools

IPV Scale	Construct	Scale Characteristics	Target population	Scale Validity
CTS developed by Straus, Hamby, Boney-McCoy, & Sugarman, 1996; Straus, Hamby, &Warren, 2003	Physical, sexual & emotional Violence	78-item scale that assesses both victimization and perpetration. The 39-item victimization scale includes 5 subscales that measure the frequency of physical assault, psychological aggression, sexual coercion, negotiation, and injury between partners. The physical assault subscale includes 12 items, which can be grouped into 2 categories, minor and severe.	Partners in dating, cohabiting, and marital relationships.	Internal consistency: Physical = 0.90 (Mechanic et al., 2000b); Physical =0.94 (Lucente et al., 2001).
DVI; developed by Risk & Needs Assessment, Inc., P.O. Box 44828, Phoenix, AZ 85064-4828, DVI-SF Copyright 2002	Physical, drug & alcohol use, & stress coping	Designed for domestic violence offender assessment. It has 155 items & six scales. It assesses behaviors and attitudes.	All adults: male & female	Alpha coefficient; 0.88-0.93
WHO Q; developed by Henrica A.F.M. Jansen (GWH/WHO, Geneva) Charlotte Watts, Mary Ellsberg and Lori Heise, and Dr Claudia García-Moreno (GWH/WHO Geneva)	Physical, sexual & Violence	Consists of 2 sets to assess the prevalence, frequency and severity of different forms of violence	Women in intimate partner & non-partner relationships.	Not available
AAS; developed by McFarlance and colleagues, 1991	Physical, sexual & emotional Violence	The oldest short DV screening tool, used for the detection of abuse during pregnancy	Pregnant women	Not available.
WEB; developed by Smith, Earp, & DeVellis, 1995, Smith, & Earp, 1999, Smith, Thornton, DeVellis, Earp, & Coker, 2002	Psychological/ Emotional	10-item scale that measures prevalence of the battering of women.	Females with current or former male intimate partners.	Internal consistency: 0.91 to 0.99.

SVAWS; developed by Marshall, 1992	Physical Victimization	46-item scale with 9 subscales that measure 2 major dimensions (threats and actual violence). The acts of violence subscale include 21 items for female victims and 20 for male victims.	Males and females reporting on abuse with an intimate partner.	Internal consistency: .92 to .96 for female college students; .89 to .96 for community women. Threats = .94; Acts of violence = .95.
ISA; developed by Hudson, 1997	Physical perpetration	25-item scale that measures the magnitude of physical abuse perpetrated against a spouse or partner.	Partners in dating, cohabiting, and marital relationships.	Internal consistency: > .90.
CAS; developed by Hegarty K and colleagues, 1999 & and modified by Hegarty K and colleagues, 2005	Physical, sexual, emotional and combine	30-items scale that measure the severity and frequency of violence	Adults in intimate relationships	Internal consistency: Physical abuse = .94. there is evidence of content, Construct, criterion, and factorial validity.
PVS; Developed by Fleshes and colleagues, 1997	Physical violence	3 brief directed questions, used originally in emergency	Female in intimate relationship.	Sensitivity: 64.5%-71.4%, specificity: 80.3%-84.4%,
BRFSS; Developed by CDC, 1984	current behaviors that affect health (e.g., tobacco use, women's health) and questions on demographic characteristic	Established in 1984 by the Centres for Disease Control and Prevention (CDC), and it is the largest telephone health survey in the world. The questionnaire has three parts: 1) the core component; 2) optional modules; and 3) state-added questions.	Designed to measure behavioral risk factors in the adult population (18 years of age or older) living in households.	Not available

1.5 Why measuring the health status of women with IPV

In the survey of IPV more specific operational definitions are required in order to facilitate research. From a research point of view, attempts have been made to solve this problem by focusing on measuring behaviour and specific acts, and their effects on women's health including physical, sexual and emotional well-being [23]. Social scientists may view health as a continuum along which people progress and regress [50]. Positive health could be described as the ability to cope with stressful situations, such as partner violence, the maintenance of a strong social-support system, integration in the community, high moral and life satisfaction, psychological well-being, and, even, levels of physical fitness as well as physical health [51]. In my thesis, I included the SF-36 health measure (full rationale for this is presented in chapter 5) for two reasons: to assess the health status of abused women and to follow the WHO Committee of Safety and Ethical Conduct Guidelines. The WHO (2005) recommends that surveys on domestic violence need to be framed as a study on women's health or family relations in order to enable women to explain the survey to others safely [52-53].

1.6 Why focus on women with IPV

Here, I discuss the rationale of selecting women as my population and as a target of IPV. It has been argued that women are targeted by their partners in some cultures, because it is believed that they as individuals – are held up as symbolic bearers of their cultural and ethnic identity and honour, and perceived as responsible for the future generations of their community [54]. This is particularly true in Arab countries, where there are factors that can be suggested to increase the vulnerability of women to abuse, for example, unfair laws that place restrictions on women's personal and economic rights, and even movements, in some Muslim and Arabic countries. This has also been addressed by studies

conducted in countries with similar cultural and/or religious backgrounds, like Pakistan, India, Mexico, Bangladesh, and Nigeria [55-59].
Saudi Arabia is known as one of the countries where the gender imbalance is very prominent. Saudi women are considered minor, regardless of their age, and they should be supervised and guarded by a male in almost every aspect of their life, including choice of marriage, education, work, and health care access [60].

Furthermore, women and men could be affected by the same health conditions, but women believed to be experienced them differently. A study reported that IPV resulted in 2,340 deaths in 2007 in the USA. Of these deaths, 70% were adult females and 30% were adult males [61]. Women also reported more fear, anger, and insult when their partners were violent than did men [62]. Women (from US) are more likely to report being injured more severely, and they seek more health care services for abuse-related issues [63]. In a recent study, in the UK, tracking cases from 2001 to 2007, (any incidents recorded in police in relation to any one partner couple), found that the intensity and severity of violence and abusive behaviour from men was much more extreme [64]. Another study, in Canada, revealed that the psychosocial consequences were also greater for women than for men with similar experiences of IPV, such as feeling upset, fearful, and confused [65]. IPV may extend also beyond women's reproductive and sexual health to their overall well-being, and the well-being of their children [66]. This gender difference in perpetration and consequences of IPV may be partially explained by the increased prevalence of poverty and economic dependence among women, their experience of violence, negative societal attitudes towards women, racial, and other forms of discrimination, the limited power many women have over their sexual and reproductive lives and lack of influence in decision-making [28]. These are often social realities, particularly in some communities, which have an adverse impact not only on women's health, but also on their future generations.

1.7 Why focus on IPV

In this section, I explain why I have chosen my thesis to be about IPV rather than domestic violence against women in general and not to include the abuse by wider family. Current literature indicates that, particularly in Asian and Arab communities, wife beating is a deeply entrenched habit and that attitudes uniformly justify it [67]. Some societies also encourage husbands to exercise their rights to dominate and control their wives. The family structure, in these communities, in which the man is the undisputed ruler of the household, supports this vulnerability and allows violence to occur against women [57].

Previous researchers have found that one of the most common forms of violence against women is that perpetrated by a husband or other intimate male partner [68]. Moreover, international research, in various countries, consistently demonstrates that a woman is more likely to be assaulted, raped, or killed by a current partner than any other person [25]. Additionally, the World Report on Violence and Health explained that:

> *women are particularly vulnerable to abuse by their partner in societies where there are marked inequalities between men and women, rigid gender roles, and cultural norms that support a man's right to have sex regardless of a woman's feelings, and weak sanctions against such behaviours (p.12) [27].*

IPV has also been found to impact negatively not only on women's health but their children's well-being, as noted in the previous section (Why focus on women with IPV).

Having decided to research Saudi women in the UK (see below section), I focused on IPV, particularly because the Saudi population living in the UK probably do not have their extended families with them, and are likely to exist as married couples, so that exposure to violence from other family members would be

unlikely. Additionally, there was a need to focus my research on a particular population group (partners) in order to help define, in-depth, their characteristics, pattern of IPV, factors involved, and health impacts of such a group. Another point is that IPV has unique dimensions of risk, which, is a function of marital status. Additionally, the aetiology of IPV may include social, cultural, and mental dimensions, which may differentiate it from violence that takes place in other contexts.

1.8 Why Saudi Women in the UK

Here, I discuss the rationale behind selecting Saudi women in the UK, rather than in Saudi Arabia, to be the study population of my thesis. Additionally, further details of the difference between Saudi women and other migrants in terms of their socio-economic profiles are discussed in the chapter 7.

The total Saudi population in the UK is estimated to be 14,000, of which 3240 are adult women (Royal Saudi Embassy, London, personal communication). A small proportion settles in the UK permanently and there are a very few asylum claims, so only 670 Saudi Arabian born nationals have been granted British citizenship since 1980 [69].

A large number of Saudi Arabians make commercially oriented trips to London or come to the UK to study, creating a community characterized by transience, with a relatively small permanent presence consisting largely of small businesses and middle-class professionals. Arabic is the official language of Saudi Arabia. However, English is widely spoken, and it is used in business. It is a compulsory second language in schools. While spoken Arabic varies from country to country, classical written Arabic has remained unchanged for centuries. In Saudi, there are differences between the dialects spoken in urban and rural areas.

Female immigrants have been identified as those particularly challenged with barriers that increase their risk of abuse [70]. Changes in status frequently occur

with migration, as stressors such as minority status, access to health care services, discrimination, isolation, and role reversals affect newcomer families and shift the power dynamics between men and women, increasing women's vulnerability to IPV [71-72].

Other factors that contribute to the vulnerability of women, who live outside their home countries, to spousal abuse include language barriers, their education, the conditions of the marriage, lack of information about legal and social services in the country in which they settle, and stereotyping by the mainstream society [73].

Focusing on immigrant women might provide an opportunity for researchers to conduct research in a safer and more open climate, like in the UK, than in Saudi Arabia. It might also be safer for participants in the UK as there are no definite legislations if women are exposed to IPV in Saudi.

1.9 Aim and Objectives

In recognition of the lack of sufficient research in the field of IPV among Saudi women to date, this project was conceived with the broad aim of:

1) Measuring the prevalence and characteristics of IPV among Saudi women in the UK
2) Exploring Saudi women experiences of such violence.

The objectives of the project were to:

1) Develop the Arabic version of the CAS questionnaire.
2) Measure the prevalence of different forms of IPV among Saudi women in the UK.
3) Assess any associations of such violence with the health status of women and their socio-demographics.

4) Explore the experiences of women who have been abused by their partners, and the views they hold about seeking help.

1.10 Structure of the thesis

A vast base of theoretical literature and empirical studies underpins research into intimate partner violence. This chapter has discussed and laid out some background information about the various issues surrounding IPV, its definition, measurements, prevalence, and the need to focus on the importance of surveying IPV among Saudi women. It has also included the study overall aim and objectives.

Chapter 2 provides an overview of the literature using a systematic approach, to understand and highlight research efforts investigating IPV using qualitative and quantitative research methods. Chapter 3 explains the theoretical framework and methodological approach that guided my thesis with discussion of the various theories explaining the aetiology and consequences of IPV.

Chapter 4 describes the method and results of the translation of the CAS and adaptation of the Arabic SF-36 health survey. Chapters 2, 3, and 4 might seem fore-loaded and of considerable length before getting to the main method and results; however, this thesis is composed of three studies in order to fulfil its multiple objectives. Additionally, investigating IPV among Saudi women for the first time needs careful and systematic preparatory steps (literature review, theoretical framework, and translation) in order to rigorously measure and explore IPV.

Chapter 5 focuses on the survey method and results, and Chapter 6 details the qualitative interviews method and results. Chapter 7 involves the thesis discussion, conclusion, and implications. In this chapter, I assimilate the survey findings with the interview findings. Chapter 4, 5, and 6 provides only the method and results of each study (translation, survey, and qualitative interviews). This structure helps me in describing the methods and results of each stage of my

thesis, and finally provides a nested overall discussion. Hence, the structure allows me to explain and discuss the findings in an integrative manner in order to highlight the estimate and experiences of IPV among Saudi women living in the UK.

Chapter 2. Literature Review

2.1 Introduction

The current study's research aims, design and methodological approach have developed from a close understanding and analysis of the existing literature. This chapter reviews the previous research literature that is directly relevant to my research objectives.

This chapter reviews previous research on the translation of CAS, and the prevalence and experiences of Arab and Muslim women of intimate partner violence (IPV). Studies conducted in other populations are also discussed in the context of my systematic review that I published in 2010 [35]. This was done in order to compare their characteristics and prevalence of IPV. Studies conducted among Muslim women were included because Islam, as a religion, plays an essential role in both Arab and non-Arab women in their way of life. This common religious identity with its major influence in people' lives made it an imperative to be included in order to understand IPV and its contexts.

This literature review aimed to answer three questions:

1) How the CAS has been translated and adapted?
2) What is the prevalence of IPV in the Arab and Muslim world?
3) What are the experiences of such violence among Arab and Muslim women?

2.2 Review Q1: How the CAS has been translated and adapted?

2.2.1 Objective of the review

- To review the literature that discusses translation and adaptation of the CAS.
- To review related guidelines and general articles that discussed translation and adaptation in general.

2.2.2 Method

Three databases were searched including: Medline, Embase, and PsychoINFO for the period between 2000 and 2009. The British Library catalogue was searched for books and other references about translating survey questionnaires using the same search words used in the databases. General search engines such as Google were searched also looking for guidelines of translation in general and survey questionnaire, specifically. This was supplemented by hand searching of the reference list from studies retrieved. Searches include MeSH and text words with combination using 'AND, OR' as Boolean operator. Search term includes: CAS, survey, questionnaire, instrument, translation, adaptation, and cross-cultural adaptation.

Studies were included if they were reporting that they translated the CAS. At this stage, I found that there were a few studies that involved translation of CAS. Hence, I decided to include further studies that described or set up guidelines regarding translation of any questionnaire, and review articles about translation, were included for review. Studies were excluded if they did not conduct translation of CAS for their research, and articles that were not specifically discussing the process of translation and/or the adaptation of survey instruments.

Studies were appraised using the COSMIN checklist, which contains standards for design requirements of studies on the measurement properties of health measurement instruments [74]. The focus of the checklist is on standards for studies on the measurement properties of Health-Related Patient-Reported Outcomes (HR-PROs). However, the authors suggested the same measurement properties are likely to be relevant for other kinds of measurement instruments. The checklist contains twelve boxes.

The COSMIN checklist is usually used as a modular tool. This means that it may not be necessary to complete the whole checklist when evaluating the quality of a particular study. The measurement properties evaluated in the study determine which boxes are relevant. Therefore, I decided to use only the box that is concerned with the translation and cross-cultural adaptation process (Appendix 1). Scoring of studies using the above checklist was conducted involving the response options: excellent, good, fair, and poor. An item is scored as excellent when there is evidence that the methodological quality aspect of the study to which the item is referring is adequate. An item is scored as good when relevant information is not reported in an article, but it can be assumed that the quality aspect is sufficient, an item is scored as fair if it is doubtful whether the methodological quality aspect is adequate. An item is scored as poor when evidence that the methodological quality aspect is not adequate. Subsequently, methodological quality score, per box, is obtained by taking the lowest rating of any item in a box ('worst score counts') [75]. For some items, the worst possible response option was defined as good or fair instead of poor because the checklist authors did not want these items to have too much impact on the methodological quality score per box. For example, item one in most boxes refers to whether the percentage of missing items is given. The only two possible answers are yes or no, which were rated as excellent and good, respectively. This does not mean, however, that they consider

it good practice if this information is not reported. It rather means that, in their opinion, a study that did not report the number of missing items can still obtain an overall score of good methodological quality for a measurement property, if all other items are scored good or excellent. Item 2 in most boxes refers to whether it was described how missing items were handled. If this is not described, this is not necessarily a fatal flaw in the study. Therefore, it was decided to score this item as fair instead of poor if it was not described how missing items were handled. Authors also pointed out that not all scoring decisions need to be used exactly as defined and what is adequate may depend on a number of issues. Hence, they recommend that users should make such scoring decisions for their own application, and that a definite score for some items was not presented. They also pointed out that the validity and reliability of the current scoring system have not yet been assessed [75].

2.2.3 Results

The Databases search identified three articles of original studies that translated CAS from English into Russian, Dutch, Turkish, and Arabic language [76-78]. The main objective of these studies was to measure IPV and its health impacts or association with mental health problems, and hence, part of the research was the translation of CAS. In these articles, description of the method of CAS translation and/or adaption was not reported in detail. Therefore, corresponding authors were contacted by e-mail asking them how they have done the translation and/or adaption of their questionnaires and whether they have published it separately in another article. Only one author kindly responded (Dr. Sylvia Lo FO Wong) who did not provide more information about how CAS translated, to what has been already reported in the original article.

My search of literature about translation revealed also one booklet, one book chapter, three guidelines, and two articles discussing the process of translation

and/or providing consensus statements on how translation and adaptation of survey instruments should be done.

The booklet discussed the key issues involved in translation of questionnaires that include achieving semantic equivalence across languages, conceptual equivalence across cultures, and normative equivalence across societies [79]. The authors pointed out that it is easy to achieve semantic and conceptual equivalence of demographic questions in different languages, as the words and ideas are more general and commonly used; however, it is harder to achieve normative equivalence, since cultures differ on how willing they are to share personal information. This booklet also highlighted that it is much more difficult to achieve all types of equivalence when translating sensitive questions since the ideas are more abstract and; in some cultures, people might resist discussing personal issues with strangers.

In a chapter of a book, the authors identified several key challenges when translating surveys, specifically when trying to maintain the intended meaning of the questions and matching the semantic (i.e. different meanings of a word and in relation to a phrase), content, and structure across the languages. The possible problems might include creating a different question than the original and creating unnecessary complicated text or improper use of the target language [80]. The authors explained the benefits of using a team approach to translation and review, and outlined several qualitative (cognitive interviews, interviewer and respondent debriefing, back translation) approaches for use in the translation process.

Guidelines for translation were: the US Census Bureau Guidelines, CAHPS (Consumer Assessment of Healthcare Providers and Systems) Guidelines for Assessing and Selecting Translators and Reviewers, and the Guidelines for

Adapting Educational and Psychological Tests developed by the International Test Commission (ITC).

The US Census guidelines outlined the methodology they used to translate survey instruments, including a five steps protocol: Prepare, Translate, Pre-test, Revise and Document [81]. The preparation step involves a summary of the scope of the project, explanation of the target audience and survey mode, and survey documentations that provided concept and terms about the subject. Pre-testing identifies problems in the translated texts. Documentation of the translation process at each step is important so that it will be possible to track the different survey versions.

CAHPS Guidelines provided guidelines for the assessment and selection of translators and translation reviewers [82]. The authors addressed three key issues: the roles of the translator and the translation reviewer, the process of selecting translators and translation reviewers, and the qualifications that each should have. The translator's role is to provide a translated text that is accurate, grammatically correct, sensitive to regional variations and written at an appropriate reading level. Translator reviewers (a committee) check the work of the translators to ensure that the text is accurate, written at an appropriate level and that all technical terminology is correct and understood by the majority of people. Translators and reviewers should be native speakers of the target language, proficient in the reading the source language, and have experience within the field of the study.

The Guidelines for Adapting Educational and Psychological Tests provided advice regarding how to properly translate tests and other assessment materials when measuring people who use different languages [83]. The guidelines emphasised the point that translators should take full account of linguistic and cultural differences between the populations for whom the adapted versions of the instruments are intended. They suggested that a rigorous instrument adaptation

process would involve at least three steps: (1) translating the test from a source to target language, (2) translating the test back into the source language (back translation), and (3) using independent teams of qualified translators to review the original, back-translated, and target language versions of the instrument to examine equivalence and resolve discrepancies.

One article discussed the Brislin steps of translation, and the authors explained their experiences in implementing the procedures in studies of two Asian immigrant populations [84]. In the Brislin method, the questionnaire is translated and back translated independently by two translators, reviewed by a team and pre-tested in a sample of the target population. Following the pre-test, the survey is administered to a group of bilingual participants; some receive the English version; some receive the target language version, and some receive both. The means, standard deviations and correlation coefficients for all versions are then compared.

In another article, researchers argued that, when data collection instruments designed for English speakers are translated into other target languages; there are some measurement errors due to poor translation procedures, inappropriate content, insensitivity of items, and a lack of knowledge of the cultural norms by researchers [85]. The authors suggested some translation and adaptation procedures to overcome these shortcomings, including consulting experts and field-testing measures within a monolingual sample of the target population and testing for face, content and construct validity in each language. Even extensive testing cannot always create equivalent items in several languages because sometimes there are no equivalent terms for a given concept. They pointed out that culture must be considered when developing the survey. For example, ideas of risk, health and need, among some cultures, may not be as dominant in other cultures that have alternative views.

2.2.4 Discussion and conclusion

This review showed that researchers using CAS did not report their translation methods adequately so that I could be able to, sufficiently, appraise, judge, and learn from the quality of their studies. The three studies I appraised were scored fair to poor in their quality of the translation and adaptation of their questionnaire. However, when authors were contacted to find out how they translated and/or adapted the questionnaire in their studies, only one author responded and was unable to locate any useful information to what already had been provided in the published article.

I decided to focus my discussion in this review, mainly on the guidelines of translation and other writers' descriptions, and the recommendations on the appropriate methods of translation and adaptation of a survey questionnaire. These guidelines and recommendations helped me to select the appropriate and accessible methods in translating the CAS and the adaptation of my survey questionnaire. This literature review provided evidence-based information, in addition, to the forward translation of the CAS, expert panel, and focus groups discussions (chapter 3), to establish the translation of the CAS in my thesis.
Hambleton emphasised that translation should be systematic with considerations to the linguistic, cultural, and psychological dimensions of the target and source languages:

> *Instrument developers/publishers should implement systematic judgmental evidence, both linguistic and psychological, to improve the accuracy of the adaptation process and compile evidence on the equivalence of all language versions. . . . Instrument developers/publishers should ensure that the adaptation process takes full account of linguistic and cultural differences among the populations for whom adapted versions of the instruments are intended.(p. 232) [86]*

Furthermore, some researchers have begun to consider whether the same questions should be asked of all populations, or whether cultural considerations

may require slightly different questionnaires in some instances such as issues specific to religion and sensitive personal matters, for example, questions in CAS that ask about sexual violence (personal communication with K. Heagrty, University of Melbourne, Victoria).

The use of systematic and rigorous methodology in translating survey questionnaires is an essential step because this would make data obtained from them more comparable to data collected using the source language instruments. The consensus of research in the area of translation suggested that independent translators should be convened to adapt items across languages and to validate the translations. Back translation is also suggested as a further quality-control check [87]. In addition, many suggestions focused on the quality of the translators. For example, Hambleton and Kanjee stated that translators should be fully proficient in both languages of interest, be familiar with the cultures associated with the different language groups, and have an understanding of the subject domain measured [88].

A second theme in the questionnaire translation and adaptations literature is that qualitative analyses of different language versions of a questionnaire or a test are insufficient for claiming that the different versions are equivalent or even parallel. The researchers required that both statistical and qualitative analyses should be performed to validate adapted tests as echoed in both the ITC guidelines and the Standards for Educational and Psychological Testing. For example, the standards explained:

> *'When a test is translated from one language to another, the methods used in establishing the adequacy of the translation should be described, and empirical and logical evidence should be provided for score reliability and the validity of the translated test's score inferences for the uses intended in the linguistic groups to be tested.' (p. 99) [89]*

The ITC guidelines emphasised similar recommendation:

> *'Test developers/publishers should apply appropriate statistical techniques to (a) establish the equivalence of the language versions of the test, and (b) identify problematic components or aspects of the test that may be inadequate in one or more of the intended populations.'(p. 22) [90]*

In conclusion, translation is not a solo activity, but a process that entails the cooperation and participation of several individuals with certain skills and professional experience. Therefore, this literature review has helped me to include all necessary steps and guidelines reported in my approach to translating CAS in my thesis. It also highlighted the use of multiple inputs of experiences in order to have a reliable and valid Arabic version of CAS. Generally, it reminded me of the importance of reporting in detail the process of translation, which I will do in the next chapter.

2.3 Review Q 2: What is the prevalence of IPV against women in the Arab and Muslim world?

2.3.1 Objective of the review

To review studies of the IPV prevalence conducted in Arab and Muslim populations.

2.3.2 Method

Search of the literature began with the standard bibliographic sources: Medline, Embase, International Bibliography of the Social Sciences, Cumulative Index of Nursing & Allied Health (CINAHL), and PsycINFO, supplemented by hand searching of the reference lists from studies retrieved and specialized interdisciplinary journals on violence, such as *Journal of Family Violence, and Journal of Interpersonal Violence, Saudi Medical Journal, and Eastern Mediterranean Health Journal,* were also searched to find studies conducted among Arab or Muslim populations.

Searches include MeSH and text words terms with combination using 'AND, OR' Boolean operator. The search words differed between databases, but were comparable (Appendix 2). For example, Medline indexed intimate partner violence as spouse abuse, and prevalence studies were indexed as cross-sectional studies. This search was updated, using the same strategy, to include 2010 and 2011 literature in order not to miss newly conducted prevalence studies in Arab and Muslim populations. In addition, I have discussed with expert researchers in the gender violence field (Dr. Hilary Abrahams and Dr. Kelsey. Hegarty), regarding their experiences in the field of researching IPVand their feedback about the best approach to measure IPV. Furthermore, I signed up for e-mail alerts in the above specified Journals to keep up-to-date with new studies. Studies conducted in the non-Muslim and/or non-Arabic countries were referred to in my results for purpose of comparison to the studies conducted among Arabic and/or Muslim women.

Articles were included if they: reported prevalence or incidence of IPV against adult women, aged ≥18 and ≤65 years, review articles, studies conducted in health care settings and population studies, and studies conducted in the Arab and Muslim women. Studies were excluded if they were narratives about domestic violence cases, studies investigating only the risk factors associated with violence, and studies concerning women aged ≤18 and ≥65 years old. All citations were exported into Reference Manager Software (version 11).

Data were extracted based on guidelines of STROBE Statement [91]. STROBE is an evidence-based approach to critically appraising observational studies. This was also complemented by using other evidenced-based criteria used previously to score specifically prevalence studies [92]. The checklist of these criteria

combined with STROBE helped in appraising and summarizing the included studies in a systematic manner. The checklist items of these criteria were: setting and specification of the participants, description of sampling method, adequate study size, response rate, valid repeatable case definition, measurement with valid instrument, report of confidence intervals or standard errors, attempt to reduce observer bias, summary of results with reference to study objectives, and discussion of the external validity of the study results. In addition, study ID, time of the study, prevalence or incidence estimates were extracted for purpose of description and identification of the included studies.

2.3.3 Results

The databases' search yielded 375 primary studies. After checking for duplicates between databases, this number was reduced to 321 studies. After screening (electronically using the Reference Manager) the titles and abstracts to assess whether the contents were likely to be within the scope of this review (epidemiology of IPV), 15 out of the 321 studies were found to be conducted in the Arab and Muslim world, so they were retrieved and retained for appraisal (Appendix 3). My updated literature review revealed four more studies published in the year 2010. Therefore, the total studies included in this review were 19 studies.

Studies varied in their quality and/or reporting of their findings conducted on IPV (scoring in Appendix 3). The majority of the included studies reported prevalence figures, while a few were incidence studies. The term prevalence would imply the number of cases of violence in a population over a certain period in a cross-sectional survey, while the incidence would measure the number of new cases of violence over usually a year in time.

Thirteen studies were population-based; six were conducted in primary health care setting, and one in obstetric and gynaecology. With reference to my worldwide

systematic review, there was a larger number (113) of studies conducted in the non-Muslim and/or non-Arabic countries. The majority of the studies were conducted in North America, followed by Europe, Africa and Asia [35]. For the purpose of comparison between Arabic and non-Arabic countries, I present below maps showing range of lifetime and current prevalence figures of different types of IPV worldwide (Figure 2-1, Figure 2-2, Figure 2-3, Figure 2-4, and Figure 2-5, all these figures were obtained from my systematic review [35]).

Life time prevalence of various types of IPV in Arab and or Muslim countries varied between10.2% and 58.7% [93-96]. Prevalence of the lifetime physical IPV varies from 11% to 80%, while current prevalence varies from 10%-41%. Prevalence of the lifetime emotional abuse ranged from 32% to 77.6%, and current emotional abuse from 10% to 81.5%. Prevalence of lifetime sexual abuse varies from 7.9% to 58.6%, and current abuse from 15% to 44.4%; Among Saudi women attending primary health care centres in Medina and using the revised CTS, showed that the current prevalence of physical abuse was 25.7% and emotional abuse was 32.8%, while lifetime prevalence of physical and/or emotional abuse was 57.8% [97].

Scoring of studies based on the eight criteria described in section 2.3.2.2 above revealed that only the WHO study scored high (8/8) fulfilling all the criteria. Other studies scored between 3/8 and 7/8.

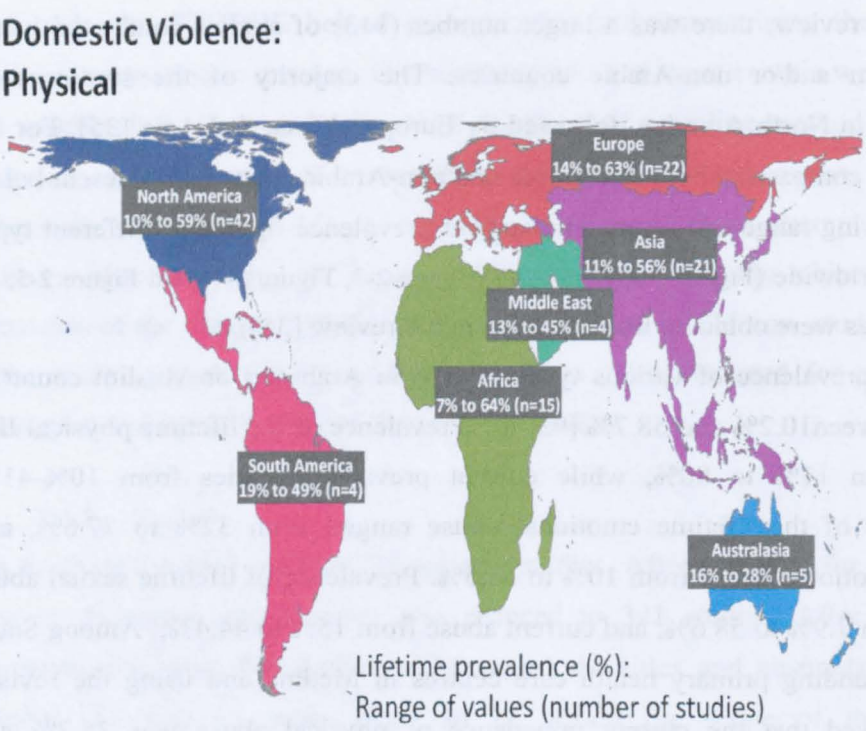

Figure 2-1: Worldwide distribution of lifetime prevalence of physical violence against women

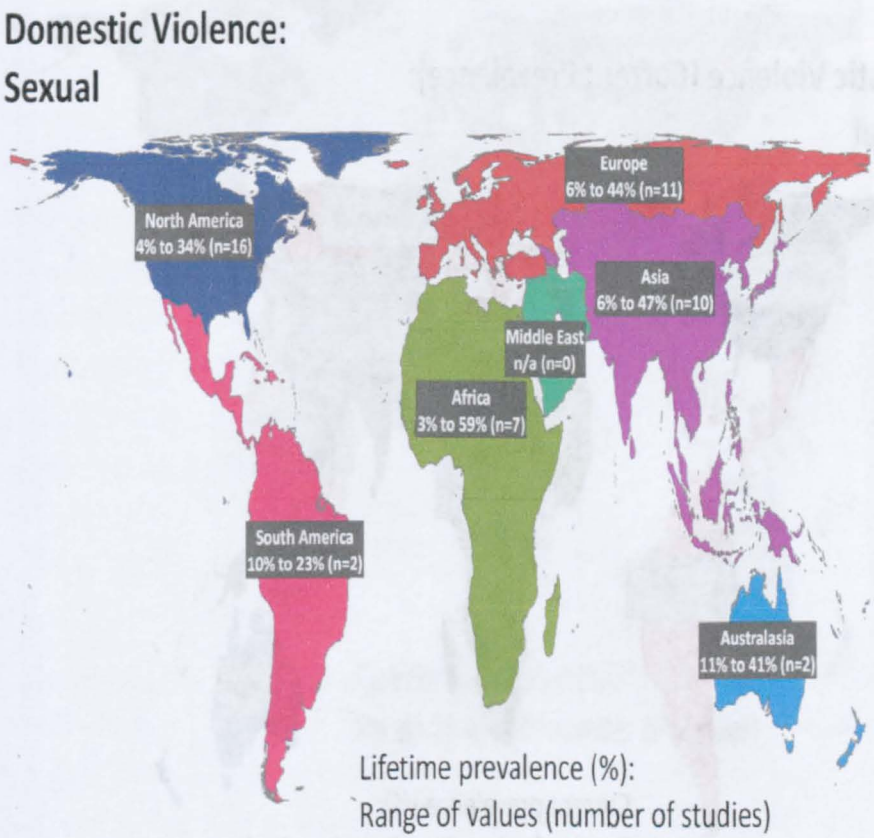

Figure 2-2: Worldwide distribution of current prevalence of sexual violence against women

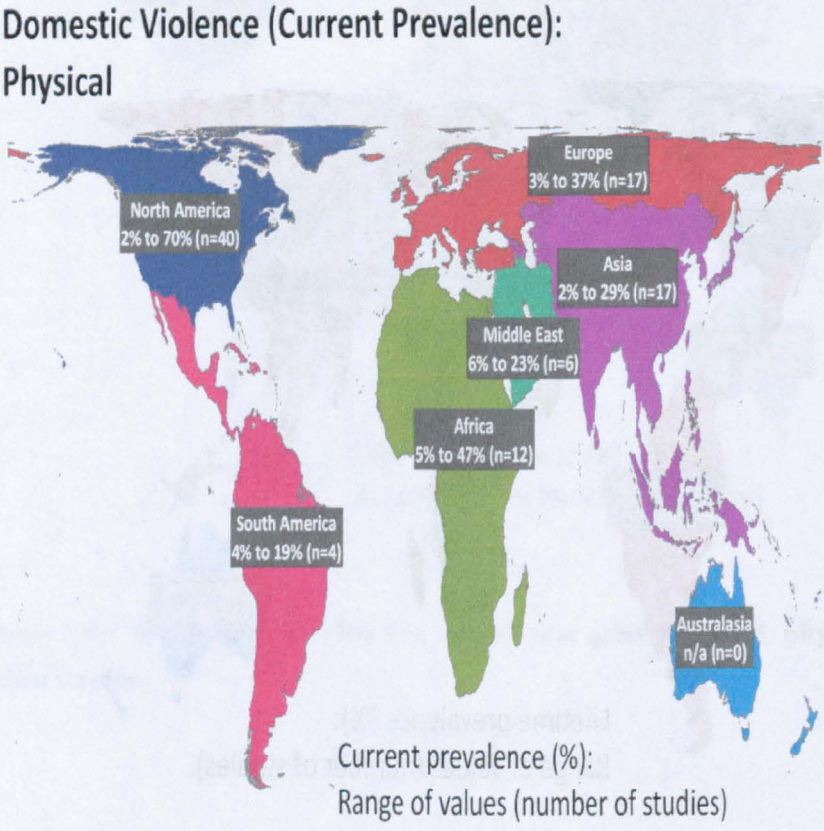

Figure 2-3: Worldwide distribution of current prevalence of physical violence against women

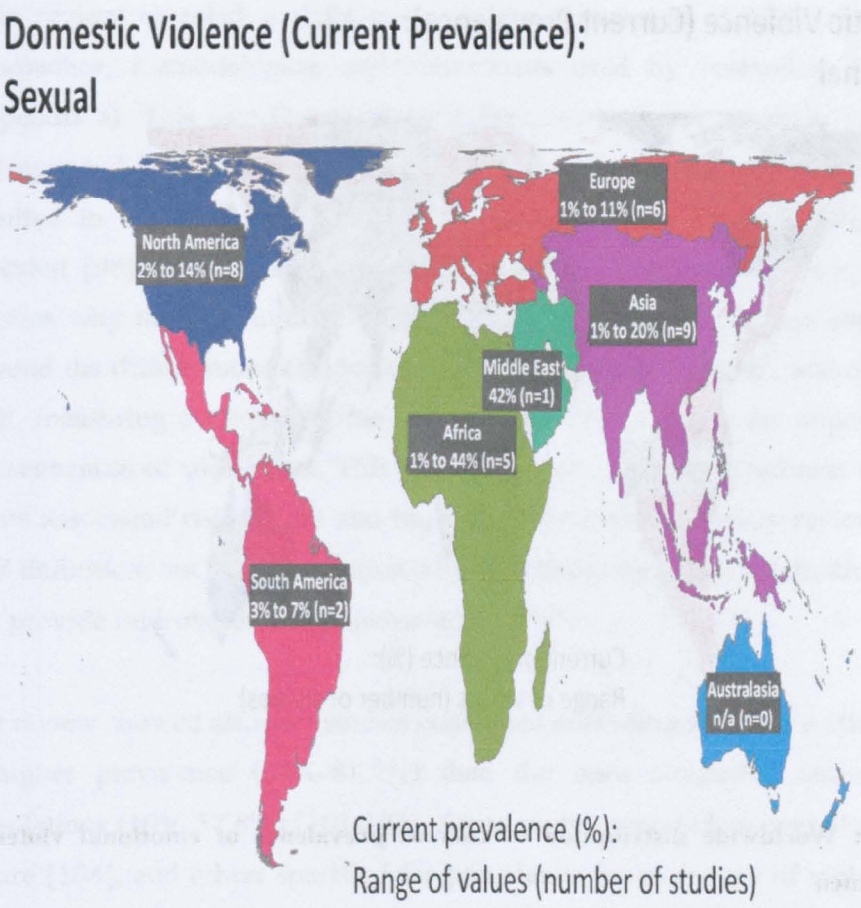

Figure 2-4: Worldwide distribution of current prevalence of sexual violence against women

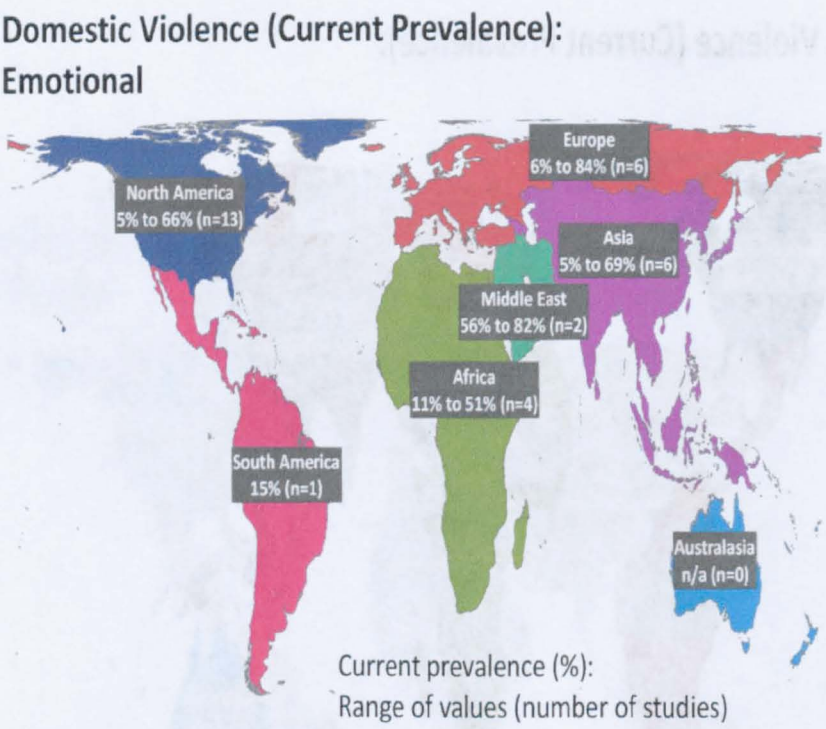

Figure 2-5: Worldwide distribution of current prevalence of emotional violence against women

2.3.4 Discussion and Conclusions of IPV prevalence

The results of this review emphasize that violence against women has reached epidemic proportions in many societies worldwide. The word, epidemic, suggests a problem that is geographically spread in a population, and IPV is not an exception to such a wide spread of an important public health problem. This review showed that there is a lack of sufficient research estimating the size of IPV in the Muslim and/or Arabic communities, compared to the English speaking (Europe and U.S.A) communities that largely reported IPV in different settings.

This review revealed a wide range in the prevalence of IPV with different approaches, methodologies, and instruments used by researchers (details in Appendix 3). This contributed to the differences in measures, definition of IPV, settings, and the methodology used to establish the prevalence of violence that resulted in the observed significant impacts on the prevalence rates that are reported [98]. Hence, definitions of IPV need to be much clearer, as do the reasons why these definitions were selected. Furthermore, surveys should move beyond the dichotomous categories of 'abuse' and 'non-abused', and consider, as well, measuring the severity, the assessment of risk factors, the impact, and the consequences of such abuse. This would not only provide an estimate of IPV but of its associated risk factors and impacts. All the studies in my review reported IPV definition, but did not mention why they have chosen such definition, and did not provide information about the severity of IPV.

My review showed also that studies conducted in health settings [99-100] reported a higher prevalence (34%-81.5%) than the ones conducted among normal populations (10%-57.8%) [101-103]. Some studies reported an overall prevalence figure [104], and others specified the prevalence for each type of violence [105-106]. The lifetime and current prevalence of physical violence were highest in studies conducted in primary care clinics, while the sexual violence was high in studies conducted in obstetric and gynaecological clinics. This might reflect that health care utilization is higher among victims of abuse and according to its type, whether sexual, physical or emotional. Campbell has highlighted that in general, prevalence of violence is assumed to be higher in clinical than in population samples [14]. One reason for this assumption is that health care utilization is higher among victims of abuse [107]. Second, high prevalence rates have been estimated in specific groups, for example, at gynaecologic clinics in patients with severe postmenstrual syndrome (PMS) or pelvic pain [108-109].

Lifetime IPV prevalence figures were higher than the current prevalence. Similar result were reported in a systematic review which showed that one-year prevalence of IPV in the UK ranged from 4.2% to 6%, lifetime prevalence in the general population ranged from 13 to 31% and in clinical settings it was 13%-35% [110].

Some researchers suggested that surveys might not measure the actual number of women who have been abused, but rather, the number of women who are willing to disclose abuse [111]. This might be true in some Muslim and Arab women who often prefer not to declare acts of IPV because of the believe that they should preserve the family unity [112]. As with all self-reported disclosure, it is possible that results are biased by either over-reporting or under-reporting. Researchers suggested that in most studies of IPV however little evidence of over-reporting has been found [111]. Therefore, prevalence rates of IPV in my review might be under-reported. Another possible reason for under-reporting might be due to fear of the social stigma when identified as abused.

In addition, it is not only important to learn whether respondents have reported any of the particular behaviours that we define as violent or abusive, but also to understand to what degree they share these labels with us as researchers. For example: some cultures belief wife beating is part of the dynamic of everyday life, and some women accept it as men's right to practice [113].

In the studies that were conducted with Arab and Muslim communities, researchers emphasized and highlighted the role of culture and religion in reporting of abuse or declaration of violence to outsiders. This was observed due to the general perception that Arab and Muslim women preferred not to declare the abuse they could be exposed to from their partners [114]. Such silence from these women was based on the notion of preserving the unity of the family and obligations of wives to obey their husbands and to fulfil the religion commands [115]. Further epidemiological research in Arab and Muslim populations should seek to recognize cultural differences in family functioning without viewing such

differences as "deviant" or pathological and should recognize the complex nature of differences between and within ethnic groups. This is particularly true in immigrant women where culture changes or even culture shock might shape or modify the family rules and relationships from their home countries (personal view). Therefore, future research efforts should consider the socio-cultural factors when measuring IPV in various communities. This would help in assessing the problem within its context, without compromising or under-evaluating the good intention of such communities in keeping the family coherence, but modifying this to be in accordance with the acceptable internationally standardized human rights.

2.4 Review Q3: How the Arab and Muslim women experience and respond to partner's violence?

2.4.1 Objective of the review

To review women's perceptions, experiences, and help seeking behaviours with regard to intimate partner violence.

2.4.2 Method

Medline, Embase, International Bibliography of the Social Science, CINAHL, and British Nursing Index were searched. Specialized journals were also searched including: *Qualitative Research Journal, Journal of Family Violence, and Journal of Interpersonal Violence.* Searches included MeSH and text words terms, with combinations of 'AND OR' Boolean operator. Terms used were: domestic violence, spouse abuse, partner abuse, battered women, female, women, Arab, Muslim, qualitative research, help seeking, behaviour, views, perspectives, experience, perception, interview, and focus group. Hand searching of the reference lists from retrieved studies was done for any studies that might not have been retrieved by the database searches. In addition, I have discussed with expert researchers (Dr. Hilary Abrahams: University of Bristol, UK, and Dr. Kelsey.

Hegarty: University of Melbourne, Victoria), regarding their experiences in the field of researching IPVand to have their feedback about the best approach to explore women's experience of their abuse. All citations were exported into Reference Manager software (version 11).

The inclusion criteria are: 1) studies aimed to explore women's views or/and experiences of IPV, 2) studies conducted in Arab and/or Muslim women 3)studies that used qualitative methods, 4) studies conducted with women aged ≥18 years and ≤65 years, 5) cross-sectional and cohort studies that had a qualitative component, 6) studies aimed to address women's help-seeking behaviours, and 7) case studies and review articles.

I excluded studies if: 1) the methods did not elicit experiences or perceptions of women who have been exposed to partner abuse, 2) the papers that did not report research studies but contained general comment on the topic, 3) quantitative studies with no qualitative component, and conducted with women in the age group ≤18 ycars or ≥65 years old.

I used the Critical Apraisal Skills Programme (CASP) to assess the quality of studies (http://phru.nhs.uk/casp/qualitat.htm). CASP has been used in previous reviews that comprehensively consider the relevance and credibility of the studies [116]. I extracted the data from studies for the purpose of description of included studies, to summarize Arab and Muslim women's experiences who have been exposed to intimate partner violence, and to gain insight of the extent of current research status in these populations.

Criteria to assess the quality of studies included: aims and settings used in studies, clear description of methods and whether the researchers have justified the design, sample size and clear recruitments procedure, whether the researchers report that

they have tried illuminating the subjective experiences of participants, whether they reported that they adequately considered the relationship between researcher and participants, details of ethical issues, clear themes/categories derived, clear statement of main findings and whether they were discussed in relation to the original research question, and whether researchers discussed their findings in relation to research-based literature. I decided not to report scoring of the studies after applying the critical appraisal criteria, because there has been considerable debate among methodologists about the value and legitimacy of scoring for judging qualitative research [117]. Researchers have suggested that the thorough assessment of qualitative research is an interpretive act and requires informed reflective thought rather than the simple application of a scoring system [118].

The results of the studies were summarized in relation to the objective of this review. In parallel with critical appraisal assessment of the included studies, analysis of these studies was conducted and included: women's expression of their experiences of IPV (understanding, beliefs, help-seeking, and any related issues to IPV), the conclusions of the researchers of the study about the overall women's experiences (see full details in the table summarizing the studies in Appendix 4), and my final interpretations about the included studies in this review. I am aware of the importance of having two reviewers to review the studies, to apply the pre-defined criteria, and to analyse data, but I had been supervised by an experienced qualitative researcher (my supervisor) and had a basic training in qualitative studies methods. All helped me in carrying out this review sufficiently to understand previous research efforts in exploring Arab and/or Muslim women's experiences of IPV and subsequently to inform my choice of how to explore my population experiences of such violence. Studies done in Western countries were retained individually for a general review in order to compare them with the Arab and Muslim women's experiences.

Critical appraisal results and data extracted from the studies were tabulated (Appendix 4) in order to read them and draw themes that were consistent across studies and/or themes, which seemed in contradiction between studies.

Final search identified 187 hits, which were screened by reading the titles and abstracts to assess whether the contents were likely to be within the scope of the objective of this review. Although my review objective is to review IPV experiences among Arab and/or Muslim women, I decided to include studies conducted among non-Arab and/or non-Muslim women. This is because I had found only three studies conducted in Arabs and/or Muslim communities. Up-to-date literature search, with similar strategy, conducted on 2010 to 2011 added another seven studies.

2.4.3 Results

I identified 25 eligible studies. The majority (16 studies) of the studies were population-based and eight were conducted in health care settings. Nine studies were conducted in the USA; and the others were conducted in Netherlands, Pakistan, Bangladesh, Uganda, Finland, the UK, Arab immigrants in the US, and Arabs in Jordan. Fourteen studies were conducted using semi-structured face-to-face interviews. Five studies used both focus groups and interviews; two studies used focus groups only; one study used self-reported statements; one meta-synthesis of qualitative studies; one systematic review of qualitative studies; and one review. In the interview studies, sample size ranged between seven to 166 women. While studies that conduced focus groups, number of groups ranged from two to 12 focus groups. Studies included in my review varied in their quality of reporting their research methods, findings, and synthesis. Only four of the primary studies discussed and explained the relationship between the researchers and participants during the interviews or focus groups discussion.

Studies included in my review have a diverse range of aims, among which were:

- Understanding factors associated with decisions, barriers, efforts, and the role of the religion to seek help [119-121].
- Exploring women's experiences and perceptions of sexual violence, in particular [122].
- Women' experiences who are immigrants, in order to understand their perceptions and more focused on their access to IPV management resources, as they live in different cultures, like South Asian women living in USA [123], or to explore the cultural experience of domestic violence among Russian-speaking women in Seattle and King County (USA) [124].
- To explore the relation of partners violence to the reproductive health of women, and the importance of exploring the role IPV plays in decision-making regarding abortion, specifically to generate a theoretical understanding of women's experiences and perceptions of intimate partner abuse during the childbearing cycle [125-126].
- To explore what women valued most in disclosing partner abuse to their doctor and whether disclosure played a role in handling their abuse situation [127].

The main finding of this review was that there had been no previous study conducted with Saudi women to elicit their experiences of intimate partner violence. However, I found three studies done in Arab populations; one was a dissertation done in Arab immigrant women in the USA [128], and the other two were primary studies.

The dissertation aimed to assess how Arab immigrant women in the US understand partner violence, what help-seeking sources they consult and what barriers they might perceive in seeking outside help. The principal researcher found that the length of stay Arab-Muslim women had been in the US influence their perception of marital violence and their help-seeking preferences. Women who had lived in the U.S longer and those with higher levels of education were

more likely to identify a larger number of situations as being examples of marital violence and this resulted in expansion of their perceptions about IPV.

In the first primary study, in the US, researchers aimed to assess the attitude and behaviours of Arab American population towards domestic violence in order to develop and implement a mass media campaign that provides relevant Arabic and English domestic violence educational materials. They reported that 58% of women and 59% of men approved the action of a man slapping his wife if she hits in an argument [129].

In the second primary study, which was conducted among Jordianian women, researchers showed various reasons why women stayed with their abusive partners. For example, the inherited social background (family not approving the idea of leaving, partners are brought up in broken and abusive families), financial dependency (low income with less education), lack of family support, sacrificing self for the sake of children, and the adverse social consequences of divorce (fear of stigma). The results indicate that Jordanian women are strongly bound by traditions and cultural rules and lack all means of empowerment [130].

Health care research efforts mainly focused on the help-seeking behaviours of abused women and whether they welcome the practice of enquiring about their experiences. Other researchers, like social scientists, tend to explore in detail women's perceptions and views of their experiences and their response to IPV. However, both social scientists and health care professionals are considered complementary in their efforts to investiagate IPV. Altought they differ in their approach to study IPV, rresearchers ought to engage in a debate about the different ways of knowing and their implications for the kinds of findings produced.

In a meta-analysis, reporting abused women's expectations and experiences when they encounter health care professionals, findings showed consistent emerging

constructs across studies [131]. The key constructs included that women wish nonjudgmental responses from health care professionals, non-directive, and individually tailored, with an appreciation of the complex nature of partner violence. Women also wanted the professional to display an understanding of the complexity of domestic violence, to understand its long-term nature, and to understand its social and psychological ramifications [131].

In another review, researchers summarized the women's experiences and redraft views from different cultures, in order to identify themes from the women's own stories and compared these themes across studies [132]. It showed that abused women's accounts of their experiences in abusive relationships, aid in understanding why they stay, how they cope, and how others can help. Many abused women have described their situation as similar to being in jail, or being a prisoner. Abused women used denial, minimizing and placating as methods of coping with their partner's violence. For example, a quote illustrated rationalization: '*Compared to others...my problems are small*' while some women address the abuse as due to a temporary situation. Other women blame themselves, '*I should not have nagged him like I did*'. Interestingly, they found that the themes and descriptions of partner abuse in Nicaragua to be similar to studies from North America, Europe and other countries. The abused women reported a significant positive influence (empowerment and legal assistance) gained from coming to the women's centre. Moreover, the review emphasized that future research is needed on minority and affluent women, who are underrepresented in the current research, as well as the role of partners' patriarchal attitudes and religious beliefs in different cultures. This is because women's stories in this review reinforced concepts such as men's use of religious ideology to justify abuse, these concepts deserve more scrutiny [132].

One study aimed to describe women's experiences of intimate partner violence, the consequences of such violence, the help they received and women's experiences of their survival revealed, interestingly, themes with typography of women's experience. One theme was "*family with no security*" which, described women's feelings that violation of intimate boundaries in childhood was a factor related to predisposing them to partner violence. Another theme was "*Women's secrets, symptoms and signs*" which, described women's views that the couple relationship failed to meet their expectations of feeling of security and to satisfy their affection needs. Other themes were: "*family life behind the scenes*" where women viewed themselves as sexual objects, living in an abusive relationship had repercussions for the physical and psychological health and social relationships of women, and "*supporting factors*" describing how survival was promoted by faith in God, family of origin, friends, and support from a good therapist [133]. This study was comprehensive, answered several questions that addressed common themes across literature and was very relevant and useful to the objectives of my thesis. The results revealed that violence occurred in situations of disagreement. Women tried to strike a balance between independence and dependence in the relationship. The different forms of couple violence were interlinked. The women sought help when their health and social relationships got worse. An awareness of the problem, taking action, counselling and social relationships helped them survive. Religiousness was a factor that involved commitment to the couple relationship, made religious demands on women and promoted the recovery of integrity. However, religion instruction as interpreted by some men (e.g. accepting forced marital sex) has also potential contradictions putting women under pressure to follow them (further detail in the discussion chapter, section 7.4.4.1).

Other studies showed that various factors could keep women in abusive relationships. These include fear of retribution, lack of alternative means of economic support, concern for the children, emotional dependence, lack of

support from family and friends, and an abiding hope that the man will change. They also demonstrated that women will ask for help after deciding to separate from their partners because the perpetrators isolate them and prevent them to access social support, and some ask for help from family and friends [134-135].

One study also showed that most abused women adopted active strategies (calling the police or seeking help from family members) to maximize their safety and that of their children. Researchers emphasised also that a lack of positive response (keeping silence and passive) by the woman might be a calculated assessment of what is needed to survive in her life and to protect the children and family [136]. This is observed in Arab population where women have to accept the abuse due to economic hardship that affected their decision to stay with the abusive partner.

Another qualitative study was conducted in the University of Bristol to explore the perspectives of Iranian female students in Iran and the UK concerning violence against women (VAW) and the differences in their attitudes to such violence in relation to the private and public spheres [137]. The participants perceive VAW to be what a 'liberty crime' and this was regardless of their locations in Iran or the UK. In addition, this was affected by the individual participants' religious ideology and their acceptance of the Iranian state gender ideology.

2.4.4 Conclusion (IPV experience review)

This literature review highlighted some of the limitations of the in-depth qualitative research in the area of violence against women in the Arab and/or Muslim world generally and no studies were conducted, particularly, among Saudi populations. Hence, there is a need to conduct further research to assess and explore Arab and Muslim women' experiences, whether in their home countries or as immigrants. Therefore, I conducted a qualitative interview study with Saudi

women in the UK in an effort to contribute to the gap in the knowledge of IPV among Arab/Muslim women.

The literature on the experience of domestic violence in different diaspora communities was potentially useful in helping me to understand Saudi women experiences of IPV in the UK. This review of literature about different communities living away from their countries of origin and their experience of IPV showed some similarities and differences between various diaspora cultures. The majority of women expressed similar stress and difficulties when living outside their home countries such as language barrier, while many thought that being away from their families might also isolate them from the rest of the society where they live as migrants. This might influence their experience of IPV as migrants, for example; because of language barriers, some women might not be aware of the available resources that are in place for abuse women. Hence, they either keep silent in response to IPV or suffer the consequences of continued abuse. These findings were very relevant to Saudi women who might have similar or different difficulties or concerns when living outside their home country. Therefore, interview studies of IPV in doaspora communities informed questions in my topic guide and allowed me to explore them in an in-depth manner during the interview stage of my thesis. The results of this review also highlighted different possible approaches to the exploration of Saudi women's experiences of IPV. Researchers have used various methods to explore women's experiences of IPV focusing on several issues regarding help-seeking behaviours, beliefs, nature and their understanding of IPV. Other women's experiences of IPV in different cultures also assisted me to include the many important topic guides in my interview with Saudi women. However, other culture's experiences of IPV might not be reflective of Saudi women's culture because of distinctive social, economic and political stability of Saudi Arabia over the last eighty years of its foundation. Hence, some of the question of the topic guide should consider these issues and the role they play in influencing Saudi women's experience of IPV.

This review highlighted variations in the quality of reporting of the qualitative studies. There was a lack of reporting of the role of researchers and their relationships with their participants. This is an important quality marker when reporting these studies as it reflects the researchers' sensitivity and awareness of the influence of their presumptions and theoretical stance on the choice of methodology and synthesis of their research findings. Therefore, future efforts by researchers need to report their identity, gender, credential, experiences, and training. For transparency, researchers should identify and state their assumptions, personal interests, and their relationship between their agenda and participants' perceptions and beliefs about their IPV experiences [138]. This will allow users of published research to be well informed when critically appraising studies and decide upon applicability of these studies to their local settings.

Generally, studies in my review have described the complex process that women go through to make sense of intimate partner violence and leave or change an abusive relationship. Studies included in my review showed that cultural, social, and religious values and expectations strongly influenced women's perceptions of the risk of intimate partner violence, particularly in immigrant Arab and Muslim women, where conflict with culture can be a risk factor for abuse. For example; the English speaking culture, which involves women going outside without the husband' s permission and working outside are the norms, might conflict with the Arab-Muslim beliefs that women should ask their partner before leaving the house. In these situations, if women chose to practice her rights where she lives, this might expose her to abuse due to her rejecting her original cultural values.

Seeking help from friends and relatives was among the most common initial help-seeking strategies used by the women. Studies have also shown that seeking help was the result of lengthy consideration, and the women needed resources to leave. Women did not usually disclose to their primary health care providers due to

shame and embarrassment if they tell their stories and fear of harm from their partners. However, women wanted doctors to emphasize that partner abuse is not acceptable and most emphasized that it was important that the doctor had asked about abuse so that it is no longer needed to be hidden. In addition, it has been found that women who after the visit to their doctor, perceived new possibilities for a change of their situations, felt encouraged and some had already acted.

This literature review informed and enriched my understanding of various women's experiences of IPV in the international community as well as in some Muslim and Arab countries. However, there is a need for further research efforts to explore Arab women's experiences (as I found only three studies). This is, particularly, true in Saudi women, in order to understand, in-depth, their experiences of such violence, to compare, and describe similarities and/or differences between them and other cultures. This would help concerned policy makers to target the needed resources and focus their effort according to their contextual environment of each population.

Previous qualitative studies also enriched my understanding of the dynamics involved in the process of acts of violence against women by their partners in various cultures. They highlighted the mechanisms abused women adopted to either live with or leave their partners. However, there is a need to replicate and modify existing various qualitative approaches to explore new or possibly unique perspectives of the Saudi women's experiences using culturally tailored strategies to understand the role of race, culture and ethnicity in the experiences of violence against women. These dimensions serve as challenges to the existing various approaches in the way we conduct research in this area. Therefore, taking a qualitative approach, implemented by myself as a Saudi woman, who understands the language of my population, and who can suggest or infer some sort of relationships (between IPV experiences and contextual factors of interest) based

on this knowledge, might yield a much better insight of the dynamics of violence in such population and across cultures with similar socio-cultural and religious backgrounds. Hence, I suggest that a study, which included qualitative interviews study, should be an essential and major part of my thesis.

2.5 Contribution of the current project to literature

Since the majority of the existing research about IPV has been generated from non-Saudi populations, there are a great number of questions to be addressed that relate to IPV. These include issues around the extent and severity of IPV that could provide a reliable figure of its proportion among Saudi women as immigrants in the UK in order to join the international community in its effort to measure IPV. There is also a need to explore and illuminate some of the possible factors that contributed to the experiences of women exposed to IPV.

Although a growing number of studies in the area of IPV are arising in the Arab world, with similar cultural background to Saudi, a great deal of work still lies ahead in order to, fully, understand the diversity of experience of such violence among Saudi women. This is currently true in a population of Saudi women, as to date, no scientific research has been conducted to elicit Saudi women's experiences of IPV. This project was designed to tackle these questions.

Chapter 3. Theoretical and Methodological Framework

3.1 Introduction

In this chapter, I discuss the theoretical orientation and conceptual framework of my thesis. Romberg affirms that more is needed to inform and guide the research in hand than just a review of previous studies:

> *An explicit description of the theoretical orientation as well as a conceptual framework for the study is required (p.56)[139]*

In this chapter, I will discuss the following: my thesis ontology and epistemology, some theories of translation and adaptation of survey questionnaires, and theories proposed in literature about IPV. Lastly, I will present my thesis conceptual framework.

I will discuss first the ontology and epistemology which informed my approach to fulfil my objectives. I have addressed these two concepts together so that what I hold to be possibly true (my ***ontology***) and what I understand of the nature of knowledge (my ***epistemology***) will be clear from the beginning.

My first objective was the translation of the Composite Abuse Scale (CAS) and adaptation of the whole survey questionnaire. Therefore, I will present initially some of the theories of translation reported in the literature that are relevant to IPV and my population. This will be followed by discussion of some of the theories conceptualizing IPV mechanisms, its causation, and possible factors underpinning its occurrence. I will then present the conceptual framework of the thesis in terms of its three objectives: to measure the ***prevalence*** of IPV among Saudi women, investigate any ***associations*** of IPV with the health status and socio-demographic profile of the abused women, and explore the women's

subjective ***experiences*** of such violence. Finally, I will discuss how the conceptual framework helped me in designing my thesis, identifying the appropriate methods, and analysing my data.

3.2 Ontology and epistemology of the thesis

Ontology and epistemology are two of the philosophical concepts underpinning research. Hence, I decided to discuss my ontology and epistemology and articulate them in relation to my research objectives. The starting point of all research is Ontology, after which comes one's epistemological and methodological positions follow [140-141]. The epistemological position in my thesis involves more than one stand as I have four research objectives, and therefore, this might urge more than one method to accomplish them. However, these methods might all be part of the same epistemological approach.

Ontology is simply the view of the world [142]. Ontology can be understood as the image of ***social reality*** upon which a theory is based. It is formally defined as:

> *Claims and assumptions that are made about the nature of social reality, claims about what exists, what it looks like, what units make it up and how these units interact with each other. In short, ontological assumptions are concerned with what we believe constitutes social reality (p. 8). [143]*

I am aware that my thoughts and view of the world are mutable and relative to the social structure of my population at the moment (Saudi women living in the UK). The formulation of IPV as a problem and my choice of methods depend on the views I have of the world (my ontology) and my views of how to attain knowledge from it (my epistemology). In this way, I would be in a position to think about how I might go about fulfilling my research objectives (translation, prevalence, associations with health status and socio-demographics, and women subjective experiences of IPV). The ways in which these objectives are fulfilled have a structure (methodology). The distinction between sets of

ontology/epistemology/methodology provides the conception. The conception is the basic set of beliefs (World-view) or thought pattern in which research is conducted [144].

All research starts from a person's view of the world, which is shaped by the experiences one brings to the research process. In my thesis, with the main subject being IPV, my experience as a G.P and my views initiated my primary research objectives (the prevalence of IPV among Saudi women, the associated factors, and nature of IPV experiences). In my thesis, I started with four objectives, which have different levels of objectivity (IPV prevalence, associations) and subjectivity (IPV experience). However, my objectives had a common overarching aim that was to investigate IPV among Saudi women in the UK. Therefore, the distinction between its components (prevalence, associations, and experiences) in terms of ontological and philosophical perspectives might jeopardize the integrity and the holistic approach I hoped to obtain in investigating IPV.

IPV (prevalence, associations) has various theories in the literature explaining its causation based on different methodologies. With this in mind, different scholarly traditions in various cultural contexts can have diverging views of the world and differing assumptions that underpin their particular approaches to any problem (e.g. IPV). This applies to IPV as a human right issue and a public health problem that exists worldwide and has stimulated diverse scholars to explore it in various cultural contexts. Therefore, when considering that different views exist regarding what constitutes reality of IPV, another question must be how that reality is measured and what constitutes knowledge of that reality.

In the context of any research (and specifically IPV research), researchers' positioning relate to their understanding of the nature of knowledge (their ***epistemological*** standpoint) and of reality [145]. Furthermore, Elizabeth Whitmore pointed to the notion that the nature of knowledge obtained from

respondents during interviews might not represent the truth and complicated by other factors at play such as culture and economy:

> *We think that respondents are telling us the truth, that we are collecting information that is valid. We think that we know the 'true' meaning of what we hear and see. This is a sad illusion. The reality is that the economic, cultural, racial and gender differences among people are profound and extremely complex. To ignore this creates knowledge that is deeply flawed. (p.97) [146]*

Patel also pointed to the kind of knowledge provided from women's experiences that were exposed to IPV and how it should be constituted:

> *All experiences and knowledge are partial, but it is only by understanding the totality of such insights that we can learn something about the true nature of oppression and the need to resist collectively without marginalising or compromising other disadvantaged voices or rights (p.81) [147]*

Hence, I should bear in mind that the knowledge obtained from exploring Saudi women's subjective experience of IPV could be partial and might not represent other women's voices. Furthermore, narratives of IPV experiences and beliefs about abuse held, culture, and their ideology are all stories by Saudi women in the UK might be influenced by the surrounding culture. In addition, being part of a diaspora community, they have to adapt to their environment, legitimate it, and give meanings to their life experiences in the UK. However, findings from a sample of Saudi women in the UK does not necessarily apply to the nature of IPV among Saudi women in Saudi Arabia (ontological position) with limited transferability to the epidemiology and experience of Saudi women more generally (epistemological position). Saudi women in the UK might be different from Saudi women in Saudi Arabia as the context in the UK might influence their experiences, response and understanding of IPV. Hence, the analysis of such experiences of IPV in the UK might not be applicable to Saudi women generally.

3.3 Translation theory (thesis objective one)

The concern for validity in translating CAS and adaptation of the survey questionnaire was the main driving force behind my search for systematic accounts and theories of translation:

> *Good theory is based on information gained from practice. Good practice is based on carefully worked-out theory. The two are interdependent. (p.1) [148]*

Gentzler described the translation theories at the beginning of the 20th century, as there was no real "systematic approach" to translation in North America and said:

> *People practiced translation, but they were never quite sure what they were practicing (p.44) [149]*

However, theories of translations have been developed. One of the theories is Nida's theory that involves four procedures of analysis, deep structure and transfer, restructuring, and testing [150-151]. This theory devises several stages of analysis, though in practice they overlap. The analysis stage involves reading the source language text (SLT) and studying it carefully, and meaning must be extracted. Analysis specifically devises several steps, though in practice they overlap. They are: (1) lexico-grammatical features of the immediate units, (2) discourse context, (3) communicative context, (4) *cultural* context of the source language (SL), and (5) the ***cultural*** context of the target language (TL). After analysing, the result of analysis is transferred into the TL, which takes place at various levels depending on the extent to which the two languages have corresponding semantic and grammatical structures. In the stage of transfer, the translator continually fluctuates between the stage of analysis and that of restructuring. Therefore, this suggests that there is no clear-cut division between these stages in the actual process of translation. Restructuring the text involves adjustment at the grammatical and semantic levels. For example, the Arabic

sentence structure implies the use of the active more than the passive. Metaphoric expressions and idioms should also be modified to match with the target language culture. The final stage is testing, which includes accuracy of readability and equivalence such as reading the text aloud, reaction to alternative, and explaining the content.

Moreover, Itamar Even-Zohar's Poly-system theory (PS) is another theory of translation [152]. He emphasized that translation should be positioned within the literary, ***cultural***, and historical contexts of the target culture. This theory views the body of translated works as a system working within and reacting to a literary system, which, in turn, is working within and reacting to the historical, social and cultural systems of the particular target audience. Therefore, there is a system within a system within a system (the poly-system, PS). The PS is important in informing my first thesis objective of translating CAS because it moves translation away from the traditional ST-TT linguistic comparisons of shift and equivalence towards the viewing of translation in a social, cultural and historical context.

Furthermore, Gideon Toury developed what is called general theory of translation [153]. He proposed three phases oriented methodology: 1) consider the text in terms of the target ***culture*** to determine its significance and acceptability, 2) compare segments of the ST (source text) and TT (target text) to determine the linguistic relationship, by mapping the TT onto the ST to find "coupled pairs", and 3) distinguish trends, make generalizations, identify norms, and draw conclusions for future decision-making. Similarly, this theory gives a prominent role to the socio-cultural aspect of translation.

Carter emphasized the importance of differentiating between a core vocabulary, which is the basic domain of lexis that a language user needs to express in a

simple context with another language speaker, and non-core vocabulary as being culture-free [154]. Based on that theory, there is core vocabulary that is free from cultural meaning and can be interpreted similarly in all contexts and ***cultures***, and non-core (culturally bound) vocabulary that should be interpreted differently from one culture to another. Arabic and English languages are different in many aspects: structurally, grammatically, and culturally. One salient feature of Arabic is diglossia, which is a situation where two different variation of a language co-occur throughout a community of speakers, each having a distinct range of social meaning [155]. Arabic people acquire different local colloquial with non-standard Arabic such as Syrian, Egyptian and Saudi, however; during education, they learnt the standard Arabic [156]. Whereas, English is non-diglossic but differentiates between spoken and written language. Therefore, I should keep in mind this feature when translating CAS by using the standard Arabic that presumably understood by all Arabic speaking populations

The translation theories discussed above informed my first thesis objective, and provided insightful knowledge to my understanding and approach to translating CAS and adaptation of the survey questionnaire. In general, all these theories provided a common theme which is that translation must be a more functionally and socio-cultural oriented concept.

Kommissarov asserted an important pragmatic point in the process of translation saying that translation theory is not a ready- made strategy but general and formulated to assist the translator:

> *Translation theory is not supposed to provide the translator with ready-made solutions of his problems. Theory is no substitute for proper thinking or decision-making. It may narrow the choice or provide a point of departure for the translator's consideration, but it cannot guarantee the successful outcome of the translating process. Theoretical recommendations are always of a more general nature. They are formulated to assist the translator in his work, but final success depends on whether they are properly and successfully applied by the translator in each particular case. (p.208) [157]*

The translations' theories also assisted me in understanding the translation process and its application considering the ***cultural contexts*** of the SL (English) and TL (Arabic).

These theories emphasized mainly on two points: 1) the importance of understanding and consideration of the cultural contexts of both languages in the process of translation, and 2) the need for an explicit systematic approach to translation. These points will be considered in the translation of CAS and adaptation of the survey questionnaire.

3.4 IPV Theories

Theories provide different explanations for IPV aetiology, associations, and consequences. Additionally, each theory has implications for response and interventions by practitioners and policy makers. Identifying theories proposed in literature that investigated the aetiology of IPV happening helped me to contextualise my findings to the appropriate theory that is relevant to my research. This also informed the selection of the methods to address the defined aim and objectives [158].

Initially, I will discuss some of the theories explaining: conceptualization of IPV measurement and factors associated with IPV. Theories may consist of formal theory, empirical evidence from previous activists and researchers, or informal observations, beliefs, and explanations from experts in the field.

In the subsequent section, I will discuss the theories surrounding IPV that are relevant to my research questions.

3.4.1 Conceptualization of *measurement* of IPV (thesis objective 2)

There is a lack of consistency in the conceptualization of both incidence and prevalence rates as well as insufficient comprehension of their utility for understanding violence against women [159]. There is actually confusion between

reporting incidence or prevalence, for example: reporting prevalence rate while what has been measured is incidence, and the opposite could happen.

The conceptualization of ***prevalence*** is that it is the ***extent*** to which violent behaviour is distributed in the population. It has been asserted that ***prevalence*** (in percentage %) is most commonly used by some researchers to refer to the ***frequency*** (number of acts) of violence, while others referred not only to the ***frequency*** but the ***extent*** (scope of IPV such as severe combined, physical or emotional) to which violence occurs [159]. Prevalence is a proportion expressed as a percentage.

Some referred to the ***incidence*** as the ***occurrence*** of violence behaviour among those in the population who experiences violence [160]. Some researchers appear to have commonly used ***incidence*** to describe the ***frequency*** of behaviour over the past year [161]. However, in epidemiology, incidence is referred to number of new cases in a population over a period of time (usually one year) [162].

With respect to the ***time frame***, there are two time frames employed in conceptualizations of prevalence: one refers to the lifetime of a relationship, and the other uses a time frame of an entire lifetime [163-164]. Therefore, the definitions of incidence and prevalence vary in two respects: the first, the ***meaning*** of the definition, and the second, ***time frame***. Therefore, these differences often render the studies incomparable. This means that a rate with a period that spans several years will be larger than a rate with a one-year reference period.

To avoid such confusions, I will place more emphasis on the definition to distinguish between prevalence and incidence. Definition of incidence refers to ***occurrence***, while definition of prevalence to ***frequency***. The CAS questionnaire asks about the violence in either during the last 12 months or at any time during the life-time of women, but focused mainly on the ***frequency*** (how many times)

and ***occurrence*** (whether it occurs or not) of each act. Therefore, it encompasses the lifetime prevalence, which includes the last year occurrence. This is in accordance with previous research indicating that period does not make significant differences in estimates of violence [165].
In the survey study, I have measured the figures of IPV as the ***lifetime prevalence*** including the number of incidents and the prevalence as proportion in order to represent adequately the extent of IPV. Reporting of the number of incidents and the prevalence will be done for each type of IPV.

Some researchers emphasized that measurement of IPV should not only focus on simple counts of behaviours, but on broader contextual factors [166]. Contextual factors not only shape what behaviours are defined as IPV but also influence the ways women respond to such violence and the environments in which they cope with abuse. There are multiple dimensions to the conceptualization of IPV, including behaviours such as hitting, power dynamics in the relationship, intent of the behaviour, consequences (e.g., those relating to health and everyday functioning), perceptions of normativeness of violence in women's lives, and severity [166]. Therefore, in any research where IPV is the key construct or a variable of secondary interest; the research needs to expand its scope to define IPV as encompassing measures of acts ***and*** situational or relational and socio-cultural contexts [167]. This systematic measurement of IPV with consideration of these contexts, will allow me to deepen the understanding of the nature and consequences of IPV. Here, I will discuss the theories that explained these factors.

3.4.2 Conceptualization of *causation, and factors associated* with IPV (thesis objectives 2, 3 and 4)

McHugh and colleagues highlighted the social construction of meaning and how individual understanding and responses to events are shaped by social factors that both support and constrain the meaning violence has in women's lives [168]. Researchers have urged greater attention to the context, and the abused women's

interpretation to better understand and interpret the social meaning of the violent acts [166-167]. Women's response, and their decision-making process to partner violence are determined by the interpretations they make of their situations. Therefore, Pape and Arias suggested that theorization and definition of IPV should include some of the women's construction and interpretation of their experiences [169].

Many factors in the literature explain IPV: biological, psycho-pathological, social and gender-based (feminist). The concept of associations of these factors with IPV, define the level of analysis (individual, couples, family, community, culture, and economic level), and the impacts to be assessed (health, psychological, and social outcomes). Knowledge and understanding of these factors are defined by different theories which helped me in deciding the survey items (age, length of marriage, no of children) and areas of investigation in the interview topic guides. The decision to include these factors depended on the statistical significance of the evidence about them in previous researchers' efforts and the feasibility of measuring such factors as some factors cannot be measured in a cross-sectional survey and might need a longitudinal follow-up design to capture their causation (biological genetic factors).

In the following section, I outlined these theories in the aetiology of IPV in order to gain insight of previous researcher's efforts in explaining such violence and to help me in deciding what factors to be measured and/or explored in both the survey and interview part of my thesis.

Biological theories include several explanations, which interact in complex ways with the other factors discussed below. One explanation suggested that head injury in men could cause them to be violent towards family members. This is due to changes to the structure or function of the brain due to trauma or

endocrinological factors [170-171]. They found that brain dysfunction and impairment due to trauma can reduce impulse control, distorts judgement and cause communication difficulties. Additionally, a gene-based explanation, focuses on sexual jealousy and male efforts to ensure sexual propriety over their partners [172]. These efforts argued to be ranged from benign attempts to win back the female, to the threats of violence and physical assaults.

Empirical evidence for these controversial ideas is not strong, but some researchers would acknowledge that biological factors can play a role in some cases. For example, in a birth cohort study (n=980), men in abusive relationships had dis-inhibitory psychopathology since childhood and extensive personality deviance [173]. In addition, there were some evidence from twin studies that supported the heritability of antisocial behaviour, but a weaker evidence for a genetic basis of violent offending [174].

These theories are difficult to test empirically because they would be costly and time consuming as they imply extensive laboratory and genetic testing and need to be done in two groups of perpetrators (control and cases) to prove the association of these medical conditions with IPV. Therefore, it is pragmatically not feasible to be tested in my thesis. Furthermore, I cannot separate the biological and social context, as we do not live in social isolation, however, researchers might remove the bias of one from the other by controlling the possible confounders such as age, gender, social class, income, and other factors to test the stability of such associations.

Psychopathological theory focuses on the psychodynamic variables of individuals, mainly, the childhood of partners and experiential events that could shape them. Empirical evidence in support of this view takes the form of surveys of populations of abusers that find high levels of certain psychiatric diagnoses, specifically borderline and anti-social personality disorders [175-176]. It suggests that there are inherited personality traits, which might predispose some men to

behave in a malicious and aggressive manner towards women [177]. Dutton pointed out that individuals with borderline personality disorder have a highly distrustful sense of self that can often be traced back to early-childhood experiences of real or imagined loss, or angry attachment [178]. This early-childhood experiences could create an angry and detached adolescent with a general feeling of inferiority. Such an adolescent, if exposed to a social environment that supports abusive behaviours towards women, he is considered at high risk of being assaultive in his adult intimate relationship [178]. Furthermore, various researchers in the field suggested that viewing IPV as a problem lying in a relatively small number of mentally disordered men might divert the attention from the societal, cultural, political, and economic factors in the society [166].

In my thesis, it would not be feasible, or even ethical, to test the personality or assess the childhood of male partners of the abused women. This is because it might be risky to the woman herself and breach of confidentiality if the partners were involved as perpetrators. Investigating the husband's personality as an abuser might also lead to retaliation by him and exaggerate the violence. However, women's subjective perspectives about their partners' childhood or characteristics, during the interviews, can highlight or suggest explanations for women's beliefs and responses to IPV. Hence, I included it in the interview topic guide, asking women about the partner's personality or characteristics and whether they think, it is related to the behaviours of their violent partners.

Social learning theory broadens the understanding of IPV to include the individual within the larger societal context in which he or she is living. Bandura contends that early experience can lead to an increased likelihood of violence in women adult life, but were not able to explicitly describe the mechanisms by which this could happen [179]. It suggests that if someone observes other behaving violently, like his or her parents, he/she is more likely to imitate it.

Researchers suggest that children who were abused might be susceptible to a latter abuse in their adult life, and this includes both partners [180]. The National Family Violence Surveys showed that men who witnessed as a child their mother being assaulted had rates of violence three times greater than those who did not [181]. This perspective is one of the most popular explanatory theories in the IPV literature [182]. This view recognized the root of behaviour in the individual's environment, particularly the behaviour of significant others, facilitated by cognition. This means that individuals observing the outcome of other behaviours learn which behaviours, even if socially improper, achieve results without drawing a negative sanction. This resulted in modelling of inappropriate behaviour for young children and can be replicated in other social interactions. This cognitive deficit is learnt and not inherited in the person. Therefore, from the perspective of social learning theory, violence is viewed as a learnt behaviour.

Furthermore, in support of the social learning theory, is the intergenerational transmission of abusive behaviour. This is the notion explaining abuse as transmitted from generation to another and commonly accepted idea in the general population [183]. Previous studies have provided evidence and supported this phenomenon [184-186]. In a recent study investigating the role of intergenerational transmission of violence on adult intimate partner perpetration in both male and female, had shown that family-of-origin violence increased odds of any IPV perpetration and psychological forms of IPV. However, investigators acknowledge other factors that could play a role in IPV such as unemployment, age, and cohabiting status [187]. Hence, longitudinal studies with follow-up of children who witnessed their parents' violence behaviour and assessed during the adult intimate relationship period, would provide evidence of such theory.

Previous researchers have shown that there are many intervening variables that may predict which children are adversely affected by witnessing their parents' abuse and which children are not. These include the presence of social support

from peers, relatives and teachers, which can help protect children from the adverse effects of exposure to violence [188-189]. Therefore, I need to consider other factors, such as how IPV affects the children who witness such violence, in analyzing my thesis findings in order to explore IPV among Saudi women and its associations with some of these factors. Furthermore, if women need to be asked about their partners' childhood, if known to them, this would be a proxy information that would not be considered valid enough and to relate it to the current violent episode. Therefore, I will consider questions in my topic guides asking women about: their partners' life in general and their perceptions about the partners' childhood. Women's perception of their partners' childhood could be explored during the interviews to gain insight also about women's beliefs around IPV, and this might explain their decision of leaving or staying with their abusive partners.

Feminist theories represent a broad range of viewpoints and political affiliations and are dynamic and pragmatic [190]. There is more than one feminist approach and some may include some of the concepts of the above discussed theories. However, they focus on the notion that men have more social and economic power than women do [191]. Their emphasis is on male dominance and gender hierarchy, for example: IPV is the result of male oppression of women within a patriarchal system in which men are the primary perpetrators of violence and the women as the primary victims [192]. Since the 1970s, the feminist perspective has been one of the predominant theoretical models in the domestic violence field, informing many programmes, interventions, advocacy efforts, and legislative agendas [193]. Early feminist perspectives primarily focused on gender as a category for analysis. Nonetheless, it has further evolved with the integration of additional components like sex and race, leading to the notion of international feminism with complex factors, which might be found across nations. This leads some theorists to propose that we should talk about our "feminisms" only in the

plural, since there is no one set of feminist principles or understandings beyond the very, very general ones to which feminists in every race, class, and culture will assent [194]. This diversity, within feminist theory, reflects different perceptions and various social and historical locations in which feminists exist.

More recently, some feminist scholars and activists have addressed the concept of intersectionality. They highlighted the importance of looking at the *intersections* between gender and other systems like race, class, age, and sexual orientation [195]. This broadened perspectives when connected violence to larger socio-cultural issues rather than the gender issue only, as it includes other factors that influence women exposure to IPV (race, culture, and society). However, new evidence of research emerged that challenged the notion that men were mostly the perpetrators of violence. Some survey showed that women are similarly violent towards their male partners and that in large proportions of cases, wives initiate violence [196-197]. However, a feminist analysis is still critical to the recognition of women's aggression, for example, Swan and Snow identified three types of abusive relationships in their study: women as victims, women as aggressors, and mixed relationships, but were cautious:

> *Even in relationships in which women were the aggressors, the women usually experienced significant violence from their partners. Women's violent behaviour can only be understood when placed in the context of their male partners' violence against them. (p. 310)[198]*

However, other studies showed that women were more likely to be injured by partner violence than men were [199]. Additionally, another study showed greater prevalence of sexual violence against women from their male partners [61]. Most of these studies used a gender-neutral-based framework and focused mainly on dating violence of young couples or adolescents [200].

Beverly and colleagues have highlighted that feminists may need to incorporate other conceptual and theoretical explanations of IPV. They state that:

> *Feminists need to consider the explanatory role of physiological and neurological factors, evolutionary psychology, substance abuse, childhood experiences of violence, intergenerational transmission of violence, shame and humiliation, attachment disorders, lack of anger control, psychopathology and difficult personality traits, general communication and coping skills deficits, personal inadequacy, and violence as a tool for constructing masculinity in explaining intimate partner violence (p.833) [193]*

Feminist activists have achieved pioneering work and effort with dedication on many levels, to address violence against women. At the individual level, they worked with abused women and their children in developing safety plans and shelters. Feminists' advocates also listened to the stories of female victims. At the societal level, feminists involved in the development of programmes treating couples with effort to gain recognition, action and change within justice and civil law.

Feminist theory (gender) is central to the analysis of my thesis, but other concepts are also equally important such as age, religion, language, meaning, and culture. The trend in literature is towards approaches, which seek to integrate valid insights from various perspectives, recognizing the complexity and multi-dimensional nature of IPV.

In my thesis, feminist theories informed my research question two (IPV prevalence) because I chose CAS as a multi-dimensional tool investigating the gender-based power coercive power, physical, and emotional acts.

Learned helplessness theory addressed IPV by explaining why some women continued to stay in abusive relationships [201]. It hypothesized that women stay in abusive relationships because constant abuse prevents them from leaving. According to this theory of learned helplessness, Walker explained that, for abused women, repeated victimization undermines the victim's perceived control of the situation and harms her ability to cope with the abuse [202]. Women often have very rational reasons for staying as they may fear retaliation against

themselves or their children, or they may not be supported financially. Walker also demonstrated the rate of associated mental health symptoms, such as low self-esteem, depression, and helplessness, which appeared in women who exposed to long term violence [203].

This theory has attracted much theoretical and practical work and has been contested by many other scholars, researchers and theories. The learned helplessness theory does not account for the fact that there are many social, economic and cultural reasons, among which, a woman might choose to stay in an abusive relationship. For example; financial needs, fear of stigma by their society, and cultural obligations that valued family unity [204-205]. Further; this theory is inconsistent with the fact that women surviving in abusive relationships may attempt to leave many times and act in very conscious ways to try to minimize the abuse directed at them and to protect their children [206].
Some actually refuted the use of learned helplessness regarding abused women by saying:

> *We think the passivity observed among victims/survivors of domestic violence is a middling example of learned helplessness. Passivity is present, but it may well be instrumental. Cognitions of helplessness are present, as is a history of uncontrollability. However, there may also be a history of explicit reinforcement for passivity. Taken together, these results do not constitute the best possible support for concluding that these women show learned helplessness [207] (p.239)*

In my thesis, the issue of why women stay with their abusive partners was discussed during the interview stage. Equally, the issue of why women leave their partners was explored.

Having discussed some of IPV theories in terms of its causation, factors, and consequences, I believe IPV prevalence and narratives are changing in various cultures across time, and therefore, theoretical alignments are constantly shifting

(see more details in the literature review chapter). Violence needs to be conceptualized within the larger evolving contexts of individual, society, culture, religion, economic, and political domains in order to capture this phenomenon [166]. Hence, from a research point of view, addressing IPV with a multilevel systematic approach is essential (individual, family, society levels) [208]. Theories exploring violence should recognize the role of culturally constructed messages created by the society itself about the expected roles of women and men, the superiority of men and right to control female. It is true that male dominance (especially in feminist theory) is the basic factor of many of the violence theories, but one should include other factors and incorporate other theories, into a model that includes the domains of each theory (discussed above), at the individual, familial, societal, economic, and political level. My thesis included several objectives, and these theories with diverse orientations, accounting for various issues of IPV such as causation, context and response to IPV would inform my thesis methodology and the analysing its data.

Although the theories, discussed above, contributed to my understanding and insight of IPV, I stand in a position where a more broad conceptual approach is needed to study IPV among Saudi women. This allowed me to capture as much as I can of the factors, the interplay of these factors, and nuance understandings of IPV. Rather than advancing a single-factor *theory*, I decided to adopt a broad ***framework*** that could reflect the complexity of real-life frequency and experiences among women. This framework called the ***ecological*** framework that ensures and acknowledges factors operating on multiple levels [209]. Ecological theory tries to understand human experience and behaviour within a "person-in-environment" framework [210]. It conceptualizes violence as a multifaceted phenomenon grounded in interplay between personal, situational, and socio-cultural factors (Figure3-1). It has been conceptualized in a variety of ways in different research settings [211]. The ecological framework includes factors that

are empirically shown to be related to violence against women. However, this framework cannot be interpreted as definitive as other factors may be missing because previous researchers have not considered them or did not test their significance in various settings and cultures.

The framework explains that behaviour is shaped by interaction between individual human beings and their social environment [212]. It has been used in relation to child abuse, neglect and domestic violence [213-214]. The framework composes of five levels: individual, micro-system, meso-system, exo-system and macro-system levels. The individual level involves the biological and personal factors that influence person behaviour. The micro-system levels include the immediate context in which abuse takes place, for example; intimate relationship or family. The meso-system level involves the interaction between a person's micro-systems. The exo-system level encompasses the institutions that embed the micro-system-neighbourhoods, social networks, and identity groups in the society where the individual lives. The macro-system level represents the general views and attitudes that permeate the culture at large [209-210].

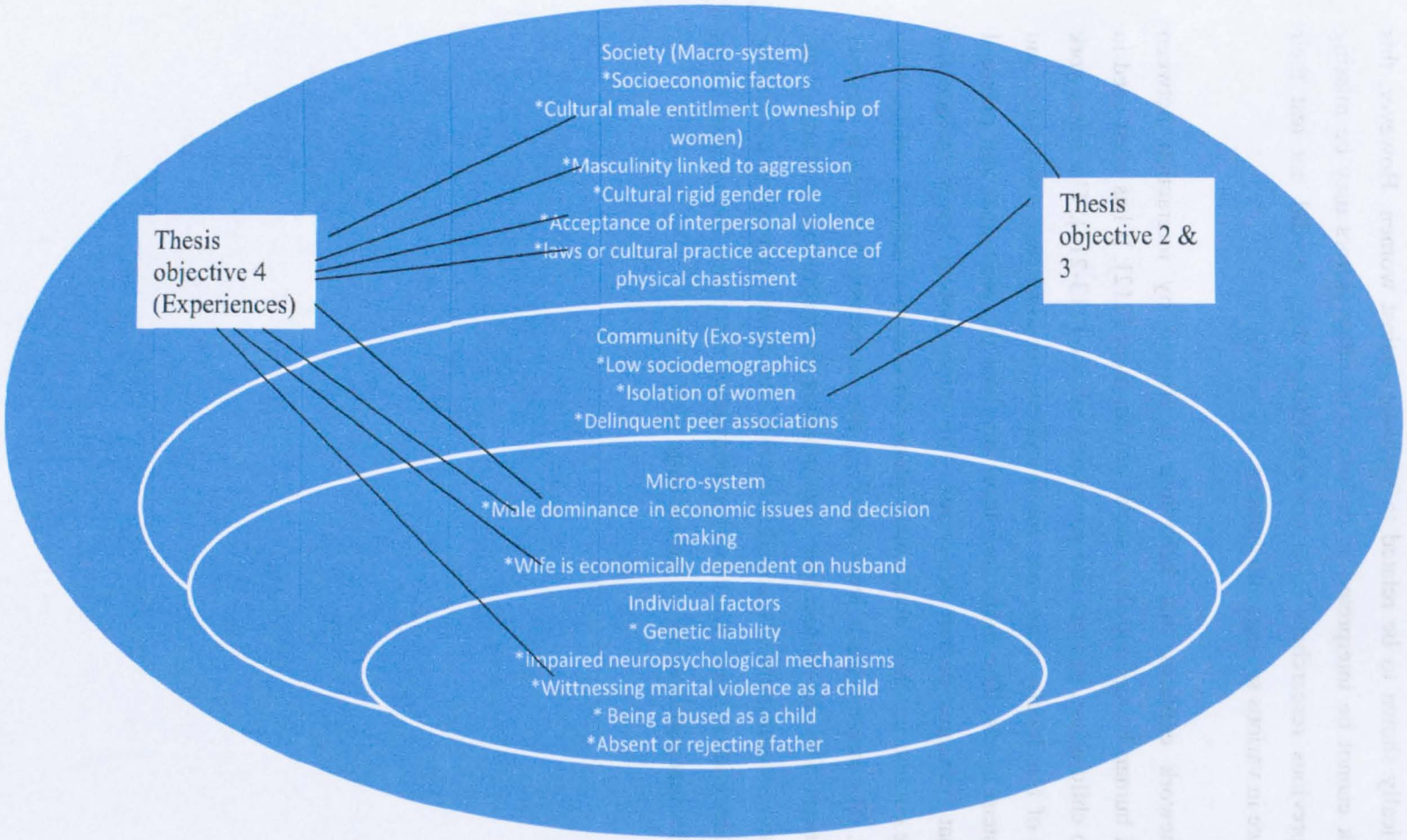

Figure3-1: Ecological Model linked to some of the thesis objectives

Furthermore, it is not only the ***factors***, but also the ***interactions*** of these factors that need to be explored. For example, as a GP, I am interested in the interplay between the women's health status and IPV. I am aware of factors and circumstances (from my experience and literature) that could play a part in the occurrence of IPV, and this allowed me to include these factors at all stages of investigating the prevalence and experiences of violence among Saudi women. In particular, factors that need to be addressed among women exposed to IPV are physical health, mental health, and social well-being. A previous study showed that abused women had lower bio-psycho-social profiles [215]. Therefore, I decided to consider the bio-psycho-social profiles in my framework, in order to explore the relationship between IPV and general health status of Saudi women.
IPV is not a static phenomenon but a dynamic human rights issue and public health problem that manifest itself differently at the personal and cultural levels. Researchers point out that:

> *The effects of interpersonal violence vary substantially from person to person and cannot be defined by pre-formulated assault syndromes or list of expected symptoms [216].*

The above-discussed theories informed my research analysis and results. My choice of the ecological framework to structure my research did not exclude the possibilities that these theories could inform, support, or even contradict some of my findings. Therefore, I would relate my findings to the relevant existing theories, as well as highlight the discrepancies. In other words, I would be inductive as much as I can in order to understand and explore IPV among Saudi women. Common sense also dictates that particular attention should be paid to the similarities and points of agreements of the different perspectives of these theories. Some of the components of the theories discussed above are embedded in the ecological framework at different levels, making it a structured guide for my thesis at every level (method, analysis, and implications). For example, these theories in common focused on individual factors (male masculinity, women

acceptance of violence, and being abused as a child), family norms (rigid gender role, witnessing violence), and societal factors (male dominance, society acceptance of IPV).

3.5 The thesis conceptual framework

The conceptual framework of this thesis is provided on the philosophy that IPV is a complex issue that is influenced by many factors, including personal, cultural, immigration, bio-psycho-social, economic, and political. It provides the link between the IPV literature to my thesis aims and questions.

The conceptual framework of this thesis is presented in inter-connecting spheres to remove any notion of hierarchy, giving fluidity to its components and to avoid any specific theoretical stance, but emphasizing the possible interconnectivity throughout the spheres. Adopting one specific theoretical stance would limit my methodological approach to factors that are specific to such a stance in both the survey and interviews. Hence, a broader theoretical approach would allow capturing a wide range of issues involved in IPV such as: prevalence, factors, associations, and experiences of such violence.

Each component of the framework provided different data (prevalence, experiences, bio-psycho-social status, associations). These data were analysed and integrated to articulate Saudi women prevalence and experiences of IPV in the UK. The framework also assisted me to make meaning of my data and provides a structured approach to communicate my findings. This was done by juxtaposition of various elements of the framework to make relevant connections, clarifications, and may be contradictions of the findings.

3.6 The conceptual framework and thesis methodology

The above-discussed conceptual framework helped me in understanding factors and associations that should be considered in measuring the prevalence and exploring the experiences of IPV among my population. For the purpose of this

thesis, pragmatically, the ecological framework assisted me also in the following stages of my project:

- The multiple thesis objectives required the use of different methods of collecting data (survey and interviews) about IPV. This was structured using the modified ecological framework. The different components of the ecological framework suggested that various information (age, children, and education level) and interactions (social support and gender roles) need to be explored to investigate IPV in order to capture its dimensions. This information would be possible to obtain by using different methods (survey and interviews)
- The ecological framework suggested that IPV involve broader issues in terms of its definition (prevalence), associations, and consequences. Hence, a broader comprehensive scale, as well as various socio-demographic and health status profiles, are needed to investigate such violence. Therefore, the ecological framework guided my choice of definition of IPV that guided my choice of the measurement tool, CAS, as a multi-dimensional scale, and other health and socio-demographic profiles (Details in Chapter 1).
- The ecological framework informed me that various information at the individual, partners, familial, and societal level needed to be explored in-depth to understand it occurrence. Hence, it informed my decision when constructing the interview topic guide that aided exploration of the subjective experiences of IPV among Saudi women (details in chapter 6).

Having explained my conceptual framework and its role in informing my approach to investigate IPV, I will discuss below the design of my thesis.

3.7 Designing the current thesis

Selection of appropriate methods is determined not only by the nature of the research questions, but also by the setting in which the research takes place [217]. This research did take place in the UK and this determined the process of the research, which involved certain standards and regulations that researchers should follow. Therefore, it was very important to decide on the approach to study a complex public health problem like intimate partner violence (IPV) concerning a specific population (Saudis) who resides outside their home country (see further discussion on section 3.2).

With the focus of my thesis being on the ***prevalence*** and ***experiences*** of IPV among Saudi women in the UK, the design of this project was influenced by the sensitivity and complex nature of IPV. This means that certain ethical standards and safety considerations needed to be implied to ensure the confidentiality and safety of participants such as informed consent, and access to help resources for abused women (more detail about ethics and safety in the survey chapter, section 5.2.3.2, and qualitative chapter, section6.2.4 & 6.2.5).
Furthermore, the multiple objectives of this project required a range of research methods to be used during this thesis to fulfil them. These methods are discussed in the next section.

3.8 Identifying Appropriate methods

A wide range of theoretical literature informed the methodological approach of my thesis, and ecological framework was of particular importance in formulating the choice of research methods and ethical stance. The ecological framework guided my research, determined what factors would be measured (***prevalence***) and other socio-demographics, what statistical relationships I would look for (***associations***), and how and what the experiences of IPV among Saudi women (***experiences***). However, not everything in the ecological framework was

included. This means that there were some issues that were not covered, e.g. income, absent or rejecting father associations. The selection of elements of the ecological framework to be measured or explored was based on the degree of importance of each factor, feasibility of doing it, its sensitivity and relevance to Saudi women culture and evidence from IPV literature.

The complexity of IPV requires that multiple methods inform our understanding of the extent and experiences of women exposed to such violence. Hence, in my thesis, I decided to use mixed methodology. This is in alignment with the definition of mixed methods:

> *Mixed methods (singular term) is a research design with philosophical assumptions as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative approaches in many phases in the research process. As a method, it focuses on collecting, analyzing, and mixing both quantitative and qualitative data in a single study or series of studies (p.5)[218]*

The mixed method approach developed into four stages. The first stage involved the study of the translation of the Composite Abuse Scale (CAS) and adoption of the survey questionnaire (chapter 4). CAS was developed originally in English, and needed to be translated into Arabic for the first time, and this implied some sort of validity (face validity), using experts panel validation, focus group discussions, and back-translation.

The second stage (chapter 5) was the study of measuring IPV and health status of Saudi women using a self-reported survey questionnaire after its translation and refinement along with the SF-36 health survey. The fourth study aimed to understand and explore the Saudi women's subjective experiences of IPV through interviews to collect rich and more descriptive data that complemented the survey.

This mixed method approach added depth and breadth to understanding IPV. Mixed methodology has been defined as the methodology that involves comparisons between qualitative and quantitative [219]. It does not dictate the use of a particular philosophical position prior to the beginning of the study, however; some researchers consider it a philosophical stand by itself and promote its use [220-221].

Researchers pointed that to fully describe any phenomenon; it is necessary to complement quantitative data with qualitative descriptions:

> *In trying to distinguish appearance from reality and lay bare the fundamental structure of the universe, science has had to transcend the 'rabble of the senses (p.14)[222]*

The above methodological approach provided a broader context that enabled the identification and exploration of the prevalence, severity (through the survey), and experiences of IPV among Saudi women (obtained from the interviews' data). Survey data gave the prevalence in numbers but did not provide the subjective experiences and why and how women were exposed to IPV, which was obtained by the qualitative interviews. In addition, other factors were measured such as socio-demographic profile, health status (SF-36 questionnaire in the survey), and their significance in the process of IPV (through regression analysis supplemented by women's narratives), spanning the entire abusive relationship from its inception to its aftermath.

3.9 The conceptual framework and analysis

The conceptual framework, discussed above, assisted me to analyze, explain and integrate my findings from surveying and interviewing Saudi women. In the survey part of my thesis, variables describing the characteristics of my population can play different roles: *independent variables* and *dependent variables*. The dependent variable was the prevalence of IPV. Variation in the extent and severity of this dependent variable was what I tried to explain in my survey. The

independent variables, also known as the predictors or explanatory variables, were the factors I discussed above, could explain the variations in the dependent variable, for example: women's education.

Other intermediate factors might influence any possible association between the dependent and independent variables. For example: IPV might affect the health status of women (physical, psychological, and social), or vice versa; the health status of women might predispose them to IPV. Identification of these correlations between IPV and variables of interest would help in targeting the resources to prevent further abuse and help women exposed to IPV according to their socio-demographic and health profile status. On the other hand, qualitatively, understanding women's subjective experiences of IPV and why some women react differently in various settings, times, and cultures could help me to explain some of the quantitative patterns and associations of the survey. Findings of the thesis might provide collectively not only the extent (***prevalence***), but also the dynamics (***associations***) and experience IPV (***interviews***) of Saudi women in the UK.

IPV is a complex problem and new factors or issues might arise from surveying and interviewing Saudi women in this current research (associations, experiences). These factors or issues are currently invisible to me at this stage prior to the results. These issues could be similar or different from previous studies in various cultures. Subsequently, results of the qualitative interviews could explain the prevalence, associations, and quality of life associated with IPV among Saudi women. For example, the strong family ties and the high social integrity that characterized the Saudi population might be mediating factors in the occurrence of IPV or could be a protective factor (personal views). In addition, the status of Saudi women as immigrants in the UK could be a cause and/or a consequence of IPV. This was because they were living far from their home

families where they could access any time if help is needed. Cross-cultural studies showed that one of the strongest predictors of societies with low levels of violence was whether family and community members would intervene if a woman were being beaten or harassed [223]. In these societies, the family considers it an obligation to intervene if women exposed to IPV, and this provides some protection to women. While in cultures with probably high violence rate, couples might be isolated from their families and considered outside of the social unit, and this isolation exposed women to IPV [224]. Hence, when analysing and integrate my survey and interviews findings, I will discuss them in relation to the ecological framework.

3.10 Reflection

In this section, I discuss my role in every aspect of the thesis in an effort to explicitly reflect on my knowledge, assumptions, and beliefs. I am aware that defining my ontological position will affect the manner in which I will take the research. I am also aware that IPV exists among Saudi women (Experience as a G.P, details in Chapter 1), there are different meanings and views of the world, and various methods of gathering knowledge about IPV exist.

I am, as a researcher as well, considered an element that influences the research epistemology, methodology, and analysis. I have my understanding of IPV; I also choose the paradigm and the methods, and I construct the knowledge from data analysis. Ramazanoglu and colleagues suggested that effective reflexivity could be done by the researcher considering and willing to discuss: the effect of power relations on the research process, the ethical judgments made, and researcher accountability for the knowledge that is produced [225]. This means that the researcher needs to be open and acknowledge her/his assumptions, beliefs, sympathies and biases. Therefore, researchers are an important part of the process of the research, and hence I will consider my part in the research process and data

interpretations by highlighting and reflecting how my personal values and beliefs influence the research process in the final chapter.

In summary, I started the thread of my thesis with different objectives (prevalence, experiences, and associations) that reflected the possible reality of IPV among Saudi women in the UK (my ontology), and this led me to think of how I could question that knowledge (my epistemology). The thread extended to how I could approach that knowledge (my methodology) and which procedures could I use to get such knowledge about IPV (my methods). Insight gained from the various theories of IPV causation, and aetiology helped me in understanding IPV from different disciplines and perspectives. The ecological framework guided my methodology, analysis, and integration of my findings. The next chapter discusses the first stage of my thesis: the adaption of the survey instrument and translation of the Composite Abuse Scale (CAS).

Chapter 4. Adaptation of the Arabic SF-36 and translation of the Composite Abuse Scale

4.1 Introduction

Different languages classify experience on different principles. In every language, groups of ideas are expressed by certain phonetic symbols, which are different from one language to another. Such variations among languages reflect the historical experiences of the people who speak them because such experiences give rise to people's thoughts and perceptions [226]. Therefore, when communicating with another culture using a certain tool or instrument, with pre-defined items, developed originally in a different language and context, we should consider not only the linguistic translation of each item but that the items capture the experiences and perceptions of that culture.

Translation is an activity of enormous importance in the modern world. It is an art as well as a skill and a science [227]. Catford has identified translation as the replacement of textual material in one language (Source Language=SL) by equivalent textual material in another language (Target Language=TL) [228]. The key term is 'equivalence'. Hence, a central task of translation process is that of defining the nature and conditions of translation equivalence.

> *The aim in total translation must be to select TL=target language equivalents not with the same meaning as the SL=source language items, but with the greatest possible overlap of situational range(p.49)[228]*

Writers on the subject of translation have approached it from different points of view regarding translation as a literary act, or as a task in computer-programming, discussing whether words or 'ideas' are to be translated. Translation from one language to another language while preserving the original meaning needs precise attention to detail, as well as the ability to see the whole picture. An accurate translation takes into consideration the dialect of place where the word is used. For example, the Arabic dictionary would translate the word عافية *'Afia'* as 'good

health'. In the Moroccan dialect, the same word is used to mean 'hell'. Moreover, the diversity of people and the geographical distances that separate them lead people to have different linguistic systems. Therefore, language is not only a set of verbal and syntactic forms (system of rules for the structure of a sentence). It also encodes a peculiar system of ideas and thoughts.

The questionnaire used in my thesis composed of three parts. The first part, the SF-36 Health Survey, had already been translated into Arabic and validated in previous studies [229-230]. However, the second part of the questionnaire, the Composite Abuse Scale (CAS) needed to be translated into Arabic. CAS originated in another language (English) within different cultural, social and political context. Therefore, the concepts may differ radically from those of another like Arabic, since every language articulates the world differently as explained above. The last part included the socio-demographics, which would be constructed in Arabic and incorporated into the questionnaire.

The aim of this Chapter is the translation and development of the Arabic version of the CAS, and the adaptation of the survey questionnaire and it's lay out as a whole.

4.2 Method

The translation of the CAS and the adaptation process of the survey questionnaire and the accompanying information sheets were conducted in four stages (Figure 4-1). In the first stage, I did the forward translation of the CAS and the information sheets. Although developed purposively to be used by Arabic speaking participants, the information sheet and accompanying documents were developed in English because I needed to discuss them with my supervisors to ensure their quality and to apply for ethical committee approval in accordance with the regulations of research conduct of the University of Bristol.

The second stage was carried out through a discussion with a panel of bilingual experts: a consultant psychiatrist, and a layperson to comment on the quality of the initial translation of the CAS.

The third stage involved two focus groups held to comment on the whole survey questionnaire, and accompanying information sheets, in terms of their format and wording, and to ensure the quality of the previous initial forward translation of the CAS.

The fourth stage involved the back-translation of the CAS by a professional independent bilingual translator in order to check the accuracy of the original translation.

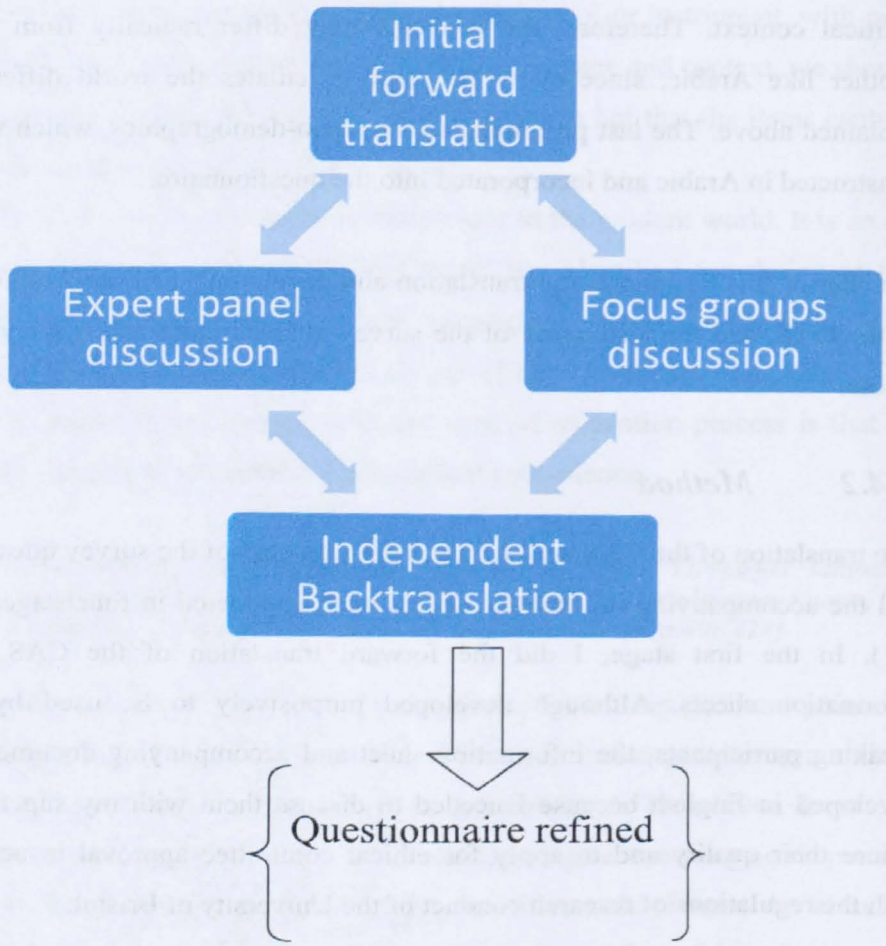

Figure 4-1 Process of CAS Translation and Survey Questionnaire adaption

4.2.1 Forward translation of the CAS and accompanying sheets by the principal researcher

The variation in the culture of English and Arabic languages makes the process of translation challenging. Being a bilingual, female, and general practitioner helped me to enhance and integrate the process of adaptation and translation of the survey questionnaire. This is because I am aware of the potential bio-psycho-social impacts of IPV on women and familiar how to communicate with them regarding sensitive issues such as IPV in terms of selecting the appropriate language, wordings, and order of items of the whole survey questionnaire.

My approach to the translation was in a back and forth manner. When I translated an item of the CAS into Arabic, I tried not to rely on the precise dictionary translation of each word, i.e. word-for-word process, but relating it to the context of the whole sentence to reflect the equivalent of the English version. I also adopted a process of paraphrasing to translate some sentences in the source text (the English CAS version) to clarify the original meaning by using other words, other than the one in the standard dictionary, to express it. This was carried out by referring back to the source text material that was developed in English, and checking comprehension of the source text by referring sometimes to the bilingual Oxford dictionary. After the target text was written in Arabic, every segment was revised twice along the way or after completion of a raw translation by reading and re-reading it loudly, to ensure the replacement of textual material in the English by the equivalent textual material in Arabic.

While some texts were easy to translate, others were difficult, for example, *Have you ever been in an adult relationship?* This question could be asked directly to women of Western culture without misinterpretation. However, if used with women from Arabic background and with certain religious beliefs, as in Muslims, it would not be acceptable as such and should be phrased into a more acceptable wording, like saying: *Have you been married before?* In these cultures, it is not

acceptable for a woman to have any kind of adult relationship apart from her socially or legally recognized husband. Therefore, words denoting social or ethical ideas or concepts usually have different meanings in different languages. These words needed to be understood as they are aimed to be given in the source language (e.g. partner) and conveyed them in the target language (husband in Arabic).

Translation took about 3 hours in total. However, it was a very intuitive process. It was almost a non-conscious cognitive exercise but with some sort of common-sense knowledge about the main concepts. Translation of CAS, for me, involved not just two languages, but a transfer from culture to another. Cultural problems often posed a great difficulty than did the linguistic problems. However, I was at least acquainted with the basic cultural features of both languages, which possibly helped me to avoid serious pitfalls in the translation process, for example; the issue of wording of the partner and husband as discussed above.

4.2.2 Panel translation of CAS

Two bilingual experts reviewed the initial forward translation of the CAS: a bilingual consultant psychiatrist, and a bilingual layperson. They were known to the main researcher and approached directly to involve them in discussing the translation of the CAS. Discussion took place at a place and time that were convenient to the panel. I was present at their discussion for more than one purpose: logistically to address the research aim and objectives, to explain the use of certain Arabic words in my initial translation of the CAS, and to facilitate and manage the flow of the discussion in revising and ensuring the validity of the translation. This is also because I was more aware of the objectives underlying the material to be translated and the concepts involved to offer a more reliable restitution of the intended survey tool.

The discussion included a linguistic validation by a comparison of the Arabic translation with the original English by assessing conceptual and content equivalence. We tried to search for a common way to express a concept in Arabic

language to ensure that the translated version maintained content validity and produce the closest natural equivalent of the English language. In addition, we read each item aloud more than once to anticipate the possible interpretations by participants. The panel meeting lasted for 2 hours and was audio taped to have an accurate record of the discussion and to allow me to review items of the questionnaire discussed.

4.2.3 Focus groups discussion of the whole survey questionnaire and accompanying sheets

Two focus groups were held with women who were contacted through a pre-existing social group in London, the Twasel Group (Saudi women working in collaboration with the Embassy). This was done to further refine the whole questionnaire and the accompanying information sheets, and ensure its acceptability to participants, in terms of its format, layout, content, and wordings. The study questionnaire, information sheet, covering letter to participant, and consent form were posted, in Arabic and English, to the focus groups members one week before the discussion date. These women had agreed to complete the study questionnaire themselves and articulated their views on its content and layout. The focus groups were held at a time and place that were convenient to the women. To systematically conduct the focus groups, a topic guide was developed to guide and facilitate the discussion (Appendix 5).

I developed the topic guides based on the purpose of the groups, in an effort to help them reflecting on the translation of CAS and accompanying documents and adaption of the whole survey questionnaire (including the SF-36 items and socio-demographic profiles). It helped to facilitate the discussion in an attempt to ensure sufficient time and flexibility to pursue unanticipated but relevant issues. This was done by phrasing and sequencing the questions so that they could easily be understood by the group's members and would gradually take them smoothly from the general questions to the more in-depth ones.

The guide covered issues of: translation and language used in the questionnaire, women's reaction to the questionnaire generally, time taken to complete it, wording, content and lay out of questions, and clarity of the accompanying documentations.

The sampling strategy employed aimed to identify a primary audience who were considered to be my greatest information-rich source to refine the questionnaire. They were, purposely, selected from pre-existing Saudi social groups, called 'Tawasel' working in collaboration with the Saudi Embassy in London. Participants in the focus groups were selected based on the needs of refining the study questionnaire and the quality of the initial translation. This allowed me to bring together diverse groups, in terms of their age and expertise relating to the field of translation in general and the violence against women, in particular, to maximize exploration of different perspectives and views on the survey questionnaire.

I attended one of the meetings of the Tawasel group in order to explain the purpose of my study and ask for volunteers. At the meeting, I provided an information sheet (Appendix 6) that gave information about the study and the purpose of the focus groups, and asked women who agreed to participate to send me their CV, in order to purposively sample them for the focus group discussions. This was done following the recommendations by the International Test Commission (ITC) guidelines that emphasized the point of looking for qualifications and experiences of the participants involved in the translation [83].

Twenty women responded to me by e-mail with their CVs. Ten of them were purposively selected based on their expertise and potential to provide different community categories, different age groups, with potential different perspectives and insights on the language, wording and lay out of the survey questionnaire

They were assigned into two focus groups, of which, four of them attended the first group while six were in the second group. Two focus groups were thought to be sufficient to cover the scope of the study because they involved the number of

different and diverse groups (heterogeneous in terms of professional and 'lay' perspectives) that were adequate to discuss the translation of CAS and adaptation of the whole survey questionnaire. Participants were invited by e-mail and were followed by phone call to ensure they had received this e-mail.

Participants were four bilingual Saudi women from similar cultural background and with different levels of knowledge and experiences of IPV. Two of them had previously worked with abused women in Middle Eastern countries and had helped charities providing aids and resources to these women. The participants' ages ranged from 35 to 45 years. Two of the group members were psychologists and the other two were specialized in the field of linguistic.

The second group consisted of six bilingual Saudi housewives, who had been selected in order to represent possibly different sector of Saudi community women living in the UK. Although they were relatively less educated and perhaps with less expertise in the area of violence against women than the first group, they were sufficiently educated and bilingual to read and comment on the survey questionnaire in both Arabic and English.
The participants' ages ranged from 26 to 40 years. The group's members knew each other and this allowed easy communication and discussion between them.

Confidentiality of the tape recordings of the discussion and transcripts were assured and signed consent was obtained before commencing the discussion (Appendix7).
Taking part in the focus groups might have several implications with regards to their safety, privacy and level of engagement in the discussion. Participation in the focus groups was voluntary. At the beginning of each group discussion, women were given the opportunity to leave the group, and informed that they could also

leave before it ended, if they choose to. However, none of them left the discussion. Participants were ensured that their comments would be anonymous and that their names would not appear on any report or publication. To protect participants' privacy, they were advised not to say their names while recording but instead to use Mrs. N or whatever was convenient for them. Furthermore, selecting the focus groups with some of them that were linked to the embassy might influence their engagement in the discussion about IPV. However, women were ensured that their participation is confidential and that their discussion and opinion expresses in the meeting would be reported anonymously.

The area of the thesis was of a sensitive nature, and there was a possibility that some of the participants in the focus group discussions had experienced IPV and might develop emotional reaction. Hence, in preparation, for such an event, that issue had been discussed within the group before starting the discussion. Additionally, a professional counsellor was arranged in advance to take care of any participants that might need help in connection with the study.

Participants were asked to complete the survey before the focus group discussions, in order to provide a state of real life situation similar to the women who could potentially participate in the main survey, and to have the time to think alone and list their comments before the meeting. However, they were not requested to hand in their completed questionnaires, but to feedback and comment on the questionnaire itself.

I arranged to conduct the groups in Regus venue in West London, which was accessible and convenient to all participants. Location and arrangement of the venue ensured adequate privacy and friendly atmosphere. Lunch was provided along with other refreshment, like coffee, tea and water.

The two focus groups took place between November and December 2008. Similar procedures were applied in both groups. At the beginning, the principal researcher, acting as facilitator, outlined the purpose and format of the discussion,

and set the group at ease. All participants were given a £10 gift voucher as a sign of appreciation for their contribution to the discussion.

The first group discussion lasted 90 minutes, while the second one lasted 120 minutes. When participants gave incomplete answers, I tried to probe for clearer responses by either repeating the question or using neutral comments, for example; "Anything else?", "Why do you feel this way?" In a very few occasions, individuals dominated the discussion. To balance out participants, I addressed questions to individuals who were quiet and reluctant to talk, or summarized the point mentioned and refocused the discussion to them.

The first group was very engaged and critical, reflecting the knowledge and understanding of the need to be engaged and motivated in such research environment. However, the second group was less interactive, members needed more encouragement to express their views, and this reflected their limited exposure and involvement in the research field. Finally, the focus groups' discussions were closed by asking the participants if there were any other comments they would like to make, and to thank them for participating.

Discussions were audio taped in conjunction with written notes taking by myself as the facilitator. These notes were used as supplementary to the tape recordings and as a backup. Thereafter, I listened to the tape recording of each focus group and then developed abridged transcript of the relevant and useful elements of the discussion.

Analysis of focus groups involved listening to the tapes, transcribing them, reading and re-reading the transcripts and the notes. I then made the necessary changes suggested by the groups. When there were disagreements between members, I encouraged the group to discuss the inconsistencies in order to reach to an agreement between them. Additionally, disagreements were used to encourage members to elucidate their point of view and to clarify why they thought as they do. I also discussed the changes proposed by the groups' members with my supervisors to ensure the acceptability and appropriateness of accepting

or rejecting the changes by the participants (see Appendix 8 for details of changes made). The refined questionnaire was then e-mailed to the focus groups members to double check the accuracy of changes suggested by them. However, no further changes suggested by the groups

4.2.4 Back-translation and comparison with the original version of CAS

A professional female bilingual translator was approached by e-mail in order to perform the back-translation of CAS. She was known to the principal researcher in a previous occasion when attending a seminar in London and was paid for her time. A copy of the Arabic CAS questionnaire was e-mailed to her, and after a period of one week, she returned the back-translated English version by e-mail. The back translator was not aware of the intent and concepts underlying the original questionnaire. Hence, she was free of biases and expectations, in order to allow her to reveal any possible unexpected meanings or interpretations in the final version of CAS.

Finally, I compared the back-translated version with the original English CAS version, to analyze, describe, and resolve any discrepancies or variations between the translations.

4.3 Results

4.3.1 Principal researcher forward translation of CAS

The initial translated version of the CAS and the accompanying sheets were completed. I thought that question number 25 in the CAS, which asked women about the use of objects in the vagina, should be removed because it was so intrusive and was not preceded by an introductory question about the sexual relationship between partners in general. However, I did not remove it at this stage and preferred to leave it for the judgments of the experts' panel and the focus groups.

4.3.2 Expert Panel translation of CAS

In addition to the linguistic considerations, the expert panel emphasized that there are psychological considerations, which place the questionnaire in a broader cultural context. For example, the wording of item one in the CAS questionnaire, intimate relationship had to be changed to be married or engaged. They thought that such modifications were required in order to deal with the emotional effect that could be created if the source language words were used. In the source language, the word intimate relationship could be offensive and may be insulting to Saudi women since it is generally not acceptable in their culture for women to have relationships outside the marriage. However, I had put their comments in the list of my notes in preparation to discuss it with the focus groups meeting, without changing the initial translation. The panel suggested deleting question number 25 of CAS, for the same reason mentioned above.

4.3.3 Focus groups discussion of the whole questionnaire

The majority of the members of the focus groups emphasized the importance of putting spaces between sections of the questionnaire or lines, to ensure the respondents know when each section ended. The initial translated texts of the CAS and accompanying information sheets, which I conducted at the beginning, were written without diacritical marks. Diacritical marks, which include accent marks, tildes, and other notations, help to distinguish one letter from another and aid in pronunciation. When added or removed, they can completely change the meaning of a word or sentence. Without diacritical marks, for example, a sentence such as, "I took with my whole hands," can also be interpreted as, "I took with my fingertips". Another example; to write the word “see” could include the meanings of seeing, understanding or recognizing. Therefore, the focus groups emphasised the importance of using these marks in order to ensure participants ‘understanding of the intended meaning of the survey questions.

The majority of participants noted that the questionnaire was of reasonable length and took approximately 10-15 minutes to complete. Only one woman from the second focus group answered the survey in 30 minutes.

To enhance participant's completion of the whole questionnaire, focus groups advised to use shorter instruction to ensure women read them completely to answer the questions. The groups agreed that the wording should be in simple Arabic forms that could be understood by everyone, instead of the probably medieval Arabic wording used in the initial translation, which implied use of complicated grammatical rules in the old Arabic language. They also, ensured use of vowel marks to clarify the exact meaning.

Focus groups also struggled in trying to find the culturally sensitive exact translation of a few words, like, for example; adult partnership. They advised me to use a broad term to address adult partnership while preserving the exact meaning of adult intimate relationship. However, they strongly recommended not using boy or girl friends, as this is was not acceptable in Saudi culture in an explicit manner in the current time.

Another point discussed among the groups was the ordering of the words. In English, ordering of a sentence is usually in the form of subject first, then verb (SVO). However, in Arabic, it is the other way round; verb then subject (VSO). Also Arabic adjectives typically follow the nouns, while in English; adjectives can either precede or follow depending on the adjective phrase length. For example, *a beautiful woman* is translated as إمرأة جميلة *imraha jamilaha* 'woman beautiful'. Therefore, this resulted in a few re-ordering of the source sentences (English) to assimilate the word order of the target (Arabic) language.

Regarding question 25 (whether partner has ever put foreign object in the vagina), both groups' members suggested removing this question from CAS for the same reasons discussed above. Removing this question from CAS might affect the

comparability of my survey with other studies that used CAS. However, I discussed this point with the inventor of the CAS (Dr Kelsey Hegarity) and she ensured me that studies conducted elsewhere using CAS had deleted the same question for similar reasons (see further detail in the discussion chapter, section 7.4.4.1).

When the focus groups read the information sheet, it was mentioned that the Embassy officer called women to have their verbal consent in order for the principal researchers to have their address. This process was a point of concern to the focus groups. They suggested that women could be contacted via the Saudi clubs, instead of the Embassy, to have their consent to provide their address to the principal researcher. Saudi social clubs were setup in each city by voluntary groups for the Saudi families to gather in each city and socialize on regular basis. However, these clubs are supported and moderated by the Embassy in London. The focus groups thought that this would make the process of recruitment less official and easier to reach. However, after discussion with my supervisors, we thought this procedure might breach the confidentiality of the participants and could be a source of risk to abused women. Thus, we decided to restrict the channel of recruitment process to the Embassy only as it is legally bound, obliged, and regulated by the UK standards of research conduct.

Thereafter, I refined the survey questionnaire and the enclosed documents in light of the comments and suggestions made by the groups' members (Appendix 8). However, to ensure the accuracy, all members were e-mailed with the refined version of the questionnaire for double-checking the suggested changes. There were no major corrections, apart from minor linguistic corrections to a few questions.

4.3.4 Back translation of CAS

Finally, the back-translated CAS showed almost similar wording and language of the original version. However, the words 'harassed' me in question 13 and 16 of

the original CAS, were back translated in question13 as 'harassed me', and in question 16 as 'threatened me'. This was translated as such because the Arabic wordings used in these two questions, obviously by me, were translated wrongly into different meanings in Arabic language (harassed in question 13 and threatened in question 16). This resulted in amplification in the back translation and therefore, revealed the above noticed failure to adapt to the target context and ambiguity in the source version was uncovered. This was the only noticed discrepancy between the original CAS and the back-translated one.

Having done the translation of CAS and adaptation of the whole survey instrument, it would be then ready for the next stage of the thesis, which is the survey stage in the next chapter.

Chapter 5. Prevalence of IPV and Health Status of Saudi Women

5.1 Introduction

This chapter reports the method and results of my epidemiological survey of Saudi women living in the UK. It addresses research objectives 2 and 3, namely: to measure the prevalence of different forms of intimate partner violence (IPV) and to assess any associations of such violence with the health status of women and their socio-demographic profiles.

5.2 Methods

5.2.1 Study Design

Developing survey instruments in IPV research has been a contested issue (crime, health, culture, policy), with various generations of tools provided that involved socio-demographic data to help understand possible societal-level factors contributing to trends in IPV [231].

The design of a study on IPV depends on many factors including the nature of the population, the setting, cost, and the research questions. Previous epidemiological studies of IPV have used different designs. For example, some researchers have undertaken postal surveys in communities while others have administered face-to-face quantitative interviews to report its prevalence [61]. Others have explored police records [232] or studied violence in various health settings (for further details, see Chapter 3).

The first research question of my thesis asks about the prevalence of IPV among Saudi women in the UK. Therefore, I decided to conduct a cross-sectional study using a self-reported abuse scale, along with a health survey (detailed rationale in Chapter 1). Combining a general health survey with an abuse scale did not only measure the extent of IPV, but allowed analysis of its associations with women's general health, as exposure to IPV has been linked to a range of physical, and psychological conditions (For more details, see chapter 1).

5.2.2 Survey instrument

The survey consisted of two instruments: the Arabic version of the RAND SF-36 health survey and the Arabic version of the CAS questionnaire (Appendix 9: Arabic version). Additional questions were included to gather socio-demographic information: age, education, length of stay in the UK, number of children, marital status and length of marriage.

The SF-36 health survey questionnaire (Appendix10: English version) is a generic tool that can provide a population-based measure of a broader health status as well as psychometrically-based physical and mental health summary measures and a preference-based health utility index [233]. The SF-36 is a multi-dimensional self-reported health questionnaire measuring health-related quality of life (HRQOL) that elicits women's own rating of their current health status. It consists of 36 items. It begins with a global question that asks respondents to evaluate their health 'overall'. It measures eight health concepts: physical functioning, bodily pain, role limitations due to personal or emotional problems, emotional well-being, social functioning, energy/fatigue, and general health perception. It also includes a single item that provides an indication of perceived change in health.

Ware developed the SF-36 questionnaire for use in the Medical Outcome Study (MOS) in the United States [233]. Since its inception, it has been used, further developed and validated in many studies reported in nearly 4,000 publications [234]. The UK version has been tested and derived from analysis of a large-scale survey dataset from the Oxford Health and Lifestyles Survey (OHLS) [235]. There has been evidence that both versions, UK and US, produced similar results both in cross-sectional and, importantly, in longitudinal surveys conducted among general populations [236]. The researcher of the last study (in UK) confirmed a similar underlying factor structure of the eight dimensions of SF-36 that have been reported on a number of US dataset. Their results suggested that in international studies, the SF-36 can be adopted and summary scores calculated for

countries where no large-scale normative dataset is available. However, they recommended that further studies are needed to confirm that the UK results are not idiosyncratic features of the UK data.

As part of the MOS, RAND (non-profit global organization) developed the 36-Items Short Form Health Survey Version 1 (SF-36) [237]. The RAND SF-36 questionnaire has been adapted and translated for use in a wide range of different countries [238]. This made it widely applicable and comparable to other population studies. For the purpose of this study, the Arabic RAND version 1 of SF-36 was used because it had been translated, validated, and adapted for a Saudi population [230]. In this validity study, the results showed that the median Cronbach's alphas (measuring internal consistency) for the Arabic RAND-36 in multiple subgroups exceeded 0.70 for every scale except the general health item, which satisfied the Nunnally's standard of acceptable reliability [239]. Two-week test-retest correlations were all statistically significant for both the English and Arabic versions. Correlation coefficients to test the equivalence of the corresponding Arabic and English versions of the RAND-36 were statistically significant and ranged from 0.73 to 0.9. The SF-36 questionnaire has been used in studies of IPV to determine the impact of such violence on the quality of life of abused women [240-242]. This ensured the appropriateness of using SF-36 along with the CAS questionnaire in my thesis to assess the health status of Saudi women exposed to IPV.

The Arabic RAND SF-36 items were placed before the main abuse questionnaire. This was because in a questionnaire design, general questions should be placed before specific ones in order to minimize bias from order effects [243]. Therefore, previous researchers suggested that the SF-36 should be presented to respondents before more specific disease items or scale to remove such potential bias [244]. Questions asked earlier in the survey might influence how participants respond to later questions. Therefore, starting with the SF-36 questions would diminish the possible influence of asking direct and difficult questions about IPV (CAS

questions) to participants before more general health questions. SF-36 items asked about general health and quality of life allowing a more smooth transition to the second part of the survey that asked about difficult issues, which, if they were placed at the beginning, might put off participants from completing the survey. Moreover, previous researchers have shown that changing the sequencing of the questionnaire items did not affect the mean scores, the amount of missing values, and the validity and internal consistency of the instruments [245-246].

Based on findings from the focus groups that discussed the questionnaire and the recommendations by the Ethics Committee of the Faculty of Medicine and Dentistry (University of Bristol), that approved this project, I changed the internal order of the SF-36 questionnaire. The recommendation was that the emotional and mental health items of the questionnaire should be put in the last part of the questionnaire, instead of being in the middle. This is because the Arabic RAND SF-36 was followed by the abuse questionnaire, which asked about the relationship with partners, therefore by putting the mental health items at the end of the SF-36 would make a smoother transition between the two measures.

To accurately measure IPV, it is necessary to assess not only whether given acts occurred but also the frequency and nature of such acts. The CAS, as discussed in chapter one, was selected to measure IPV among Saudi women because it is a multi-dimensional tool that has been developed to measure the frequency and severity of different types of IPV. CAS also assess the impact of IPV on women's well-being, in particular, fear from partners which reflects the stress and level of anxiety abused women might exposed to due to such violence (see previous discussion in the literature review chapter). CAS is a 30-items self-reported questionnaire. CAS has an internal consistency of 0.94 and a strong evidence of content, construct, criterion, and factorial validity (*see details of comparison between CAS and other abuse scale in chapter1*)

In order to describe the characteristics of abused women, respondents were asked to answer socio-demographic questions on age, number of children they have, how long they have been in the UK, marital status and how long they have been married, and education level of the women and their partners. This was placed in the last section of the survey, in accordance with previous researchers' recommendations of best practice when conducting surveys. They emphasized the importance of items sequencing in a questionnaires and recommended that demographic questions should be placed at the end of the questionnaire [247] (see more detail in chapter 4). The question of how long a woman has been in the UK was based on IPV in diaspora communities in other cultures where a link has been found between the length of stay and IPV (see more detail in the discussion chapter, section 7.4.3.1).

5.2.3 Participants

The sample size (m) was determined by the target precision of the prevalence estimate using the following equation:

$$m = \text{anticipated prevalence} \times (1\text{-anticiptated prevalence})/SE^2$$

With a target precision of 10%, if the anticipated prevalence of IPV is assumed to be around 40% (ie. O.4 in the above equation), based on previous studies conducted in similar Arab populations [93, 248], and with an aim of 95% confidence interval of 35% to 45% (anticipated prevalence ±1.96SE), 400 completed questionnaires would allow estimation of the true proportion of domestic violence in these women. Assuming a response rate of 50% and a completion rate of 80%, 1000 questionnaires were posted with the aim of achieving a target of 400 completed questionnaires. These assumptions were conservative because this is the first time that the Arabic version of the CAS has been used, and the first survey of its kind to be attempted in Saudi women.

To select the appropriate sample, a list of all Saudi women living in the UK was obtained from the Saudi Embassy in London (*sampling frame*) where all Saudi citizens are required to register. The Saudi Embassy was the only feasible source of information about the Saudi population living in the UK. Their data set contains only the name, address, and contact information (telephone and/or e-mail) about any Saudi individual who lives in the UK. There were 3240 women registered with the Embassy.

The full postcode sector allowed capturing some of the smaller scale variability, which would be lost using Local Authority Districts only. Each individual, through their postcode, was linked to the Lower Super Output Area (LSOA geographical unit) they reside in. This was accomplished through the use of a look-up table available from the Office of National Statistics [249]. In turn the deprivation score (IMD 2007) of the LSOA of each individual was linked through another table available from the Department of Communities and local government. Thereafter, the Index of Deprivation scores (one indicates the most deprived and five indicated the least deprived) were linked to the post codes where women live in different areas of the UK (Figure5-1). Then five quintiles of deprivation were generated and a pseudo-random number for each individual (algorithm that generates a sequence of approximately random numbers) was generated in Excel to select 200 potential participants from each quintile (proportionate stratified sampling), giving the 1000 as required by the sample size calculation. This stratification was conducted to ensure geographical coverage of Saudi women in various areas of the UK, and possibly to provide a reliable sample for the Saudi population as a whole living in the UK. In addition, with a stratified sample, participants would be sure to be represented in every quintile.

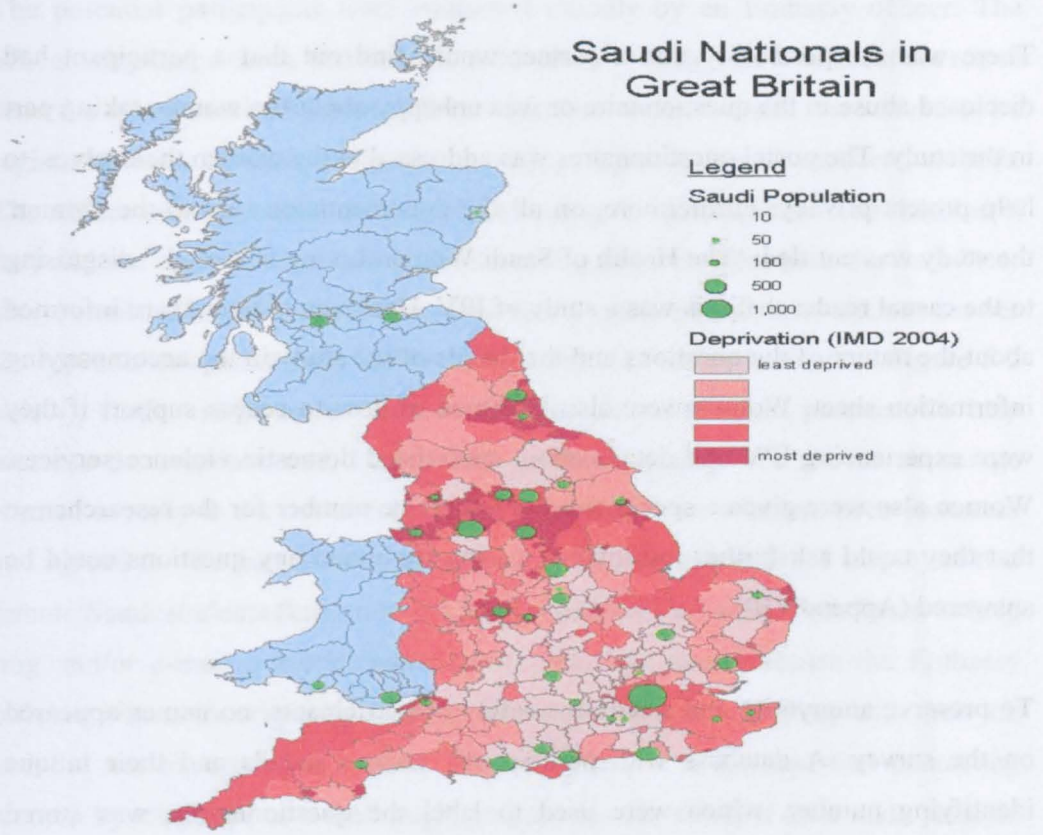

Figure5-1: Distribution of Saudi population in the UK

5.2.3.2 Ethical considerations

This study was reviewed and approved by the ethics committee of Faculty of Medicine and Dentistry in the University of Bristol. Given the sensitivity of the subject area, the study could potentially cause psychological distress to women taking part. The information sheet attached to the questionnaire stated that they did not have to take part in the study or answer a question if they did not want to. The women were asked to read the information sheet before deciding whether or not they were willing to complete and return the questionnaire. Women, who, on reading the information sheet or questionnaire, decided they did not want to take part, were asked to return a freepost card indicating their decision.

of 2009), which prevented delivery of some of the questionnaires or return of the completed ones.

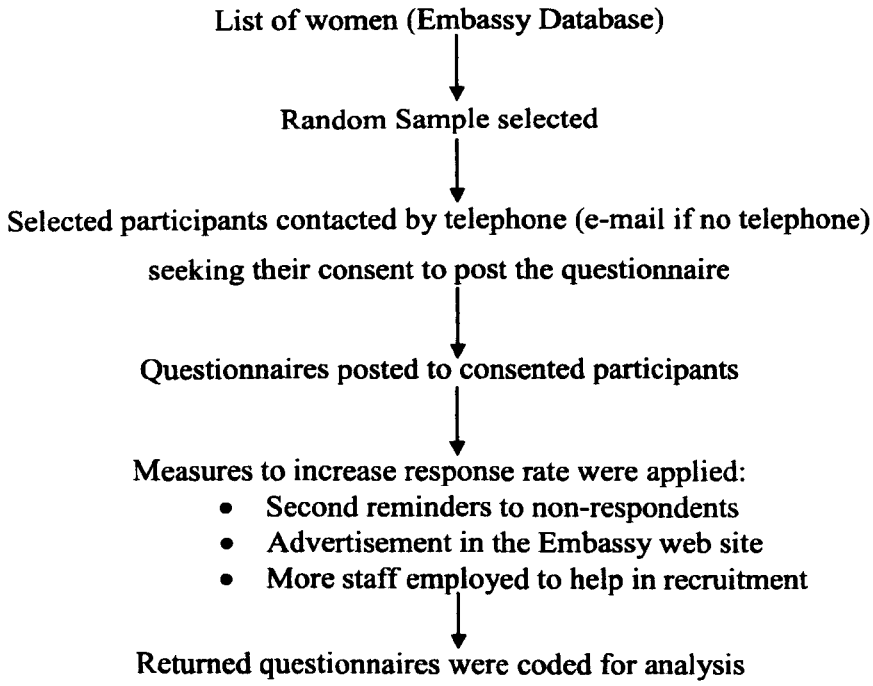

Figure 5-2: flow diagram of the recruitment process

Women were included after the officer identified that they were aged ≥18 years, living in UK as a resident (had a resident Visa), and who had been contacted by the Embassy and agreed to being sent the questionnaire. Other inclusion criteria were applied after the questionnaire was completed by the participants, specifically whether women were currently married, had been married before or were in an intimate relationship with a partner

Women were excluded if they reported to the caller from the Embassy that they were not able to read. After the questionnaires were returned, women who were not and/or never had been in an intimate relationship with a partner, were excluded.

There was the possibility that a partner would find out that a participant had disclosed abuse in the questionnaire or was unhappy about the women taking part in the study. The postal questionnaires was addressed to the women themselves, to help protect privacy. Furthermore, on all the documentation sent to the women, the study was entitled: 'The Health of Saudi Women Living in the UK' disguising to the casual reader that this was a study of IPV. However, women were informed about the nature of the questions and the details of the study in the accompanying information sheet. Women were also informed of how to access support if they were experiencing IPV and details about specialised domestic violence services. Women also were given a special contact telephone number for the researcher so that they could ask further information on the study and any questions could be answered (Appendix10).

To preserve anonymity and ensure the safety of participants, no names appeared on the survey. A database with participants' contact details and their unique identifying number, which were used to label the questionnaires, was stored securely on password-protected computers at the University of Bristol. In addition, participants were not identifiable in any written or verbal reports from the research as only summary statistics rather than individual cases could be reported from the survey data.

The database of the Saudi population in the Saudi Embassy provides limited information about its population. Each Saudi citizen was encouraged voluntarily to register with the Embassy using a specific sheet that contains their name, address, and a copy of the passport. However, update of such data could not be guaranteed, as Saudis might be moving around UK without informing the Embassy. Hence, this might contribute to further delay in the process of recruitment.

The potential participants were contacted initially by an Embassy officer. The officer telephoned them, and described the study seeking verbal consent for me to send the questionnaire by post to their addresses. Some women were found to be registered in the Embassy with their e-mails, telephone contact numbers, or both. The officer tried to contact the participants using the telephone method first, but if they did not respond after four attempts during different time periods, the officer sent e-mails asking for women' s consent. As many participants did not answer the repeated telephone calls and/or did not reply to their e-mails (see Figure 5-2 below), further steps were taken to enhance the recruitment process. To help increase the response rate, I advertised on the Embassy web site to encourage women to reply to the initial contact and to remind those who had been contacted and agreed to take part, to return the questionnaire. Furthermore, I employed two female Saudi students (known to the Saudi Embassy), on a part time basis, to help ring and/or e-mail potential participants. This was done because the Embassy officers, who were originally assigned to contact women, were busy with their job and did not have time to contact all participants. I understand that contacting women by telephone or e-mail might jeopardise their safety if their male partners came to know about them taking part in the research, however, callers from the Embassy were cautious and informed them that the study is all about women's health and the well-being of their marital relationship (see more discussion in chapter 7, section 7.2.1).

Each questionnaire was given a consecutive identification number so that the non-respondents could be contacted for a reminder. The questionnaire was posted to women along with a covering letter and an information sheet explaining the purpose of the study, a freepost return postcard to decline further contacts and a pre-paid envelop in order to return the completed questionnaire (Appendix 11). The reminder was sent to women if no response was received after one month. There were some logistic obstacles faced during the recruitment period such as Royal Mail strike and adverse weather conditions (heavy snow during the winter

5.2.4 Data Collection and Analysis

After the completed questionnaires were received by post at the University of Bristol, eligible women were included for analysis and the questionnaire of excluded ones were destroyed. The raw data were initially entered into an Excel spreadsheet. These data were then transferred into STATA (Version 10) using the "insheet" command for reading data from a spreadsheet program.

A codebook with variables and their labels was created. Variables representing the participants' responses to each question were created and coded using abbreviations or the whole text to label them, and including the question number in order to identify the questionnaire item that supplies the data. Using the index of deprivation for participants in various areas of UK, a comparison between the respondents and non-respondents was made to examine the possibility of a bias by economic status of neighbourhood to be introduced by the incomplete response rate. Unfortunately, age was not included in the database of the Embassy. Hence, I was unable to check for differential response by age (discussion of this problem and impact on the sampling are detailed in the discussion chapter, section 7.2.3.2).

Categorical variables were expressed as frequencies and percentage, and were summarized in tables. In addition, the frequency distribution of each continuous variable was assessed for normality, patterns of skewness in distribution, outliers and to summarize location and spread.

Relationships among variables were presented in graphs. The main dependent variables are: women's experience of severe combined abuse, physical abuse, physical and emotional or/and harassment, physical abuse alone, and emotional abuse or/and harassment. These variables were created using the five responses categories to the questions, which measured the number of times a woman experienced any specific act of violence in each of the violence categories. Responses were summed across each type of violence categories. The 0-5 for each item gives a possible score for each sub scale of severe combined abuse (0-35), physical abuse (0-35), emotional abuse (0-55), and harassment (0-20). To

calculate how much each woman experiences abuse and what type of abuse she was exposed to (independent experiences of abuse), combinations of the four dimensions experienced by women were derived to give a combined statistics of four major types of abuse. The first category was all women who have experienced severe combined abuse with any of the other dimensions or by itself. The second category was women who have experienced physical abuse in combination with emotional abuse and/or harassment. The third category was women who have experienced at least one episode of physical abuse alone. The final category was those women who have experienced emotional abuse and/or harassment alone [250].

The individual sub-scale cut off scores, for each type of abuse, is one for the combined abuse scale, one for physical abuse, 3 for emotional abuse, and 2 for harassment (Table 5-2). However, these cut off scores are arbitrary and based on the need to maximise the true positive number of abused women and to reduce the false positive.

Scales in SF-36 were transformed linearly to a 0 to 100 possible range of scores, with 0, 100 representing the least, and most favourable health state, respectively. All scores reflect the percent of the total possible score for that scale.

5.2.3.7 Analysis of relationships between variables

Potential associations between the main dependent variables (prevalence estimates of all types of IPV and the different items of the SF-36) and other potential explanatory or predictor variables (socio-demographic profile) were examined in three stages. The first looked at the individual correlations between different types of IPV prevalence using Chi-square test in order to get basic information about the data (Appendix 12 and Appendix 13). The second stage was an univariable logistic regression analysis in order to assess association of IPV with each potential explanatory variables listed below (Table 5-1). If there was evidence of association (providing a significant p value=$\leq$0.05) between the various types of IPV, scores and any assumed explanatory variables (based on previous literature

association findings, and the factors discussed in the theoretical framework Chapter), then the contribution of such variable would be further tested by its addition to the third stage of analysis. The third stage was a Multivariable regression analysis to determine significant associations between the study variables. However, some of these independent (explanatory) variables in the model were a mix of quantitative variables, e.g. role limitation due to emotional problems (0-100), and categorical variables, e.g. partner education score (1, 2, and 3 categories). Therefore, the categorical variables were transformed to dummy variables to conduct logistic regression analysis; this is because I did not wish to assume that the scale of categorical variables was linear in relation to IPV score.

Table 5-1: List of potential associations between IPV and the other possible study variables

Variable
Socio-demographics and score/types of IPV:
Women's age
Partner's age
Number of children
Partner's education
No. Of years living in the UK
Years in marriage
SF-36 variables and score/types of IPV
Physical functioning
Role limitation due to physical health
Role limitation due to emotional problems
Energy/fatigue
Emotional well-being
Social well-being
Pain
General health

Table 5-2: Scoring of CAS

Severe Combined Abuse (8 items), possible score=0-40, cut off score=1	***Emotional Abuse*** (11 items), possible score=0-55, cut off score=4
Raped me	Told me that I wasn't good enough
Took my wallet and left me stranded	Told me that I was stupid
Used a knife or gun or other weapon	Did not want me to socialize with my female friends
Tried to rape me	Told me that I was crazy
Kept me from medical care	Became upset if dinner/housework wasn't done when they thought it should be
Locked me in the bedroom	Blamed me for causing their violent behaviour
Refused to let me work outside the home	Tried to turn my family, friends and children against me
Put foreign objects in my vagina	Told me that no one else would ever want me
	Told me that I was ugly
Physical Abuse (7 items), possible score=0-35, cut off score=2	Tried to keep me from seeing or talking to my family
Pushed, grabbed or shoved me	Tried to convince my family, friends and children that I was crazy
Hit or tried to hit me with something	
Shook me	***Harassment*** (4 items), possible score=0-20, cut off score=2
Slapped me	Harassed me over the telephone
Threw me	Followed me
Kicked me, bit me or hit with a fist	Hung around outside my house
Beat me up	Harassed me at work

Table5-3: Variables, research questions and items on the survey ordered according to the thesis objectives

Variable	Research Question	Item on Survey
Severe Combined Abuse	Prevalence of *severe combined* IPV	CAS Section B: Qs 6,10,14,17,23,26,29
Physical and Emotional abuse or/and harassment	Prevalence of *physical and emotional or/and harassment* IPV	CAS Section B: Qs 1,4,8,9,12,20,19,21,24,27,28
Physical abuse	Prevalence of *physical* IPV	CAS Section B: Qs 3,11,13,16
Emotional abuse and/or harassment	Prevalence of *emotional and/or harassment* IPV	CAS Section B: Qs 2,7,15,18,22
General Health	General health status association with IPV	SF-36 Section A: Q1
Social Functioning	Social well-being association with IPV	SF-36 Section A: Qs 20,27
Emotional Well-being	Emotional well-being association with IPV	SF-36 Section A: Qs 29,30,31,33,35
Physical Functioning	Physical well-being	SF-36 Section A: Qs 3,4,5,6,7,8,9,10,11,12
Role limitations due to Emotional Problems	Role limitations/emotional association with IPV	SF-36 Section A: Qs 17,18,19
Role Limitations due to Physical problems	Role limitations/physical association with IPV	SF-36 Section A: Qs 13,14,15,16
Energy/Fatigue	Energy/Fatigue association with IPV	SF-36 Section A: Qs 28,32,34,36
Pain	Pain association with IPV	SF-36 Section A: Qs 21,22
Women's age	Socio-demographics relation to IPV	C section at the end of questionnaire
Women's education	Socio-demographics relation to IPV	C section at the end of questionnaire
Partner's education	Socio-demographics relation to IPV	C section at the end of questionnaire
No. Of children	Socio-demographics relation to IPV	C section at the end of questionnaire
Marriage duration	Socio-demographics relation to IPV	C section at the end of questionnaire
Length of stay in the UK	Socio-demographics relation to IPV	C section at the end of questionnaire

5.3 Results

Of the 1000 women randomly sampled, 747 (74.7%) were found to have a complete registration data in the Saudi Embassy while 253 women did not. Of these, 403 (54%) were contacted by telephone and 344 (46%) were emailed (total=747). A final sample of 369/747 (49%) women were posted the questionnaire and the rest declined to be sent the questionnaire, or did not reply the email, and/or did not answer the repeated telephone calls (**Figure 5-3** for detailed response).

The response rate would be 21% (160/747) if we calculate it from the original target sample (747). However, the original target sample was actually doubled (400×2) in order to account for the non-respondents and an anticipation rate of 50%. Furthermore, the initial response rate of women who were actually sent the questionnaire was 32% (119/369). A reminder to the non-respondents increased the response rate to 43% (160/369). This later response rate was based on the fact that the 369 participants are the denominator in terms of response to the questionnaires which were actually sent to women that gave their verbal consent.

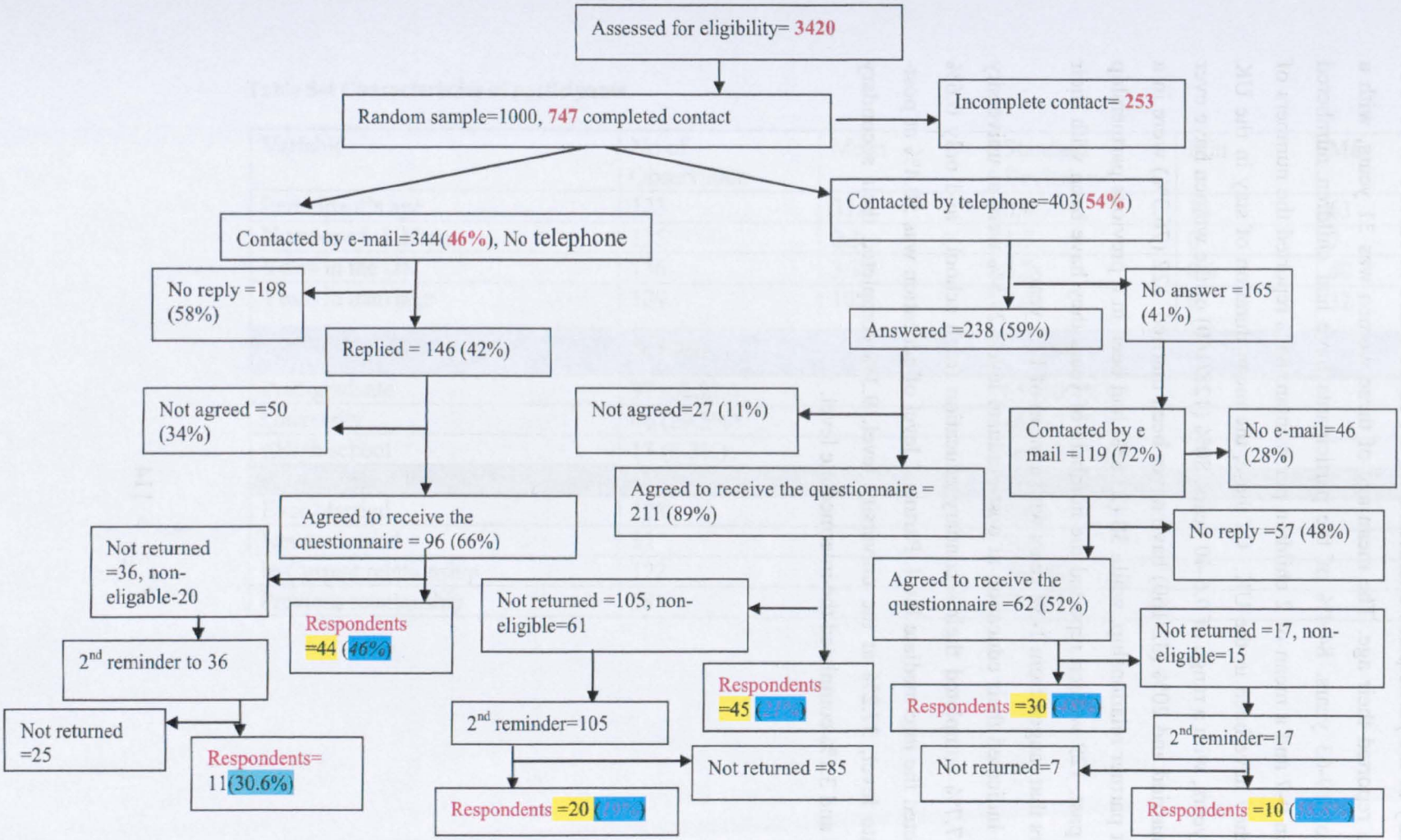

Figure 5-3: Study recruitment flow diagram. **Note: percentages in a box refer to the proportion from the box directly above.**

5.3.1 Socio-demographic profile of participants

Summary of the participants characteristics are summarized in Table 5-4. 77% of women reported their age. The mean age of these women was 31 years, with a range of 19-63 years. 84.4% of the participants have had children numbered between 0-7 and a mean of 2 children per woman. 85% reported the numbers of years they have been in the UK. Of these, the mean duration of stay in the UK was 3 years, with a range of 0.6-40 years. 80% (128/160) of the women have ever been married and 20% (32/160) have never been married. 122 (76.3%) were in a current partner relationship, while 38 (23.8%) had been in a previous partnership in the past. 129 women reported the numbers of years they have been with their partners that ranged from 1-32 years with a mean of 10.3 years.

62.2% indicated their education at post-graduate level, 29.5% were at university level, 7.7% completed their secondary education (high school), and only 0.6% completed the intermediate level. Partners' level of education was 50.4% at post-graduate level, 37.2% at the university level, 9.3% completed their secondary school and 3.1% completed the intermediate level.

Table 5-4 Characteristics of participants

Variable	No of Observation	Mean	Standard Deviation	Min	Max
Participant's age	123	31.4	6.4	19	63
Number of children	135	2.3	1.7	0	7
Years in the UK	136	3.3	4.2	0.6	40
Years in marriage	129	10.4	7.4	0	32
Education level	Women		Partners		
Post-graduate	97 (62.2%)		65 (50.4%)		
University	46 (29.5%)		48 (37.2%)		
≤High school	13 (8.3%)		16 (12.4%)		
Partnership status	No		Percentage		
Ever Married	128		80%		
Never married	32		20%		
In Current relationship	122		76.3%		
Previous relationship	38		23.8%		

The only characteristic of the non-respondents available was their full postcodes and this allowed a comparison of the neighbourhood deprivation status with the respondents. The highest response was from women living in the least deprived area of the UK (IMD=5). However, there was no statistically significant difference between respondents and non-respondents in terms of their IMD (one=most deprived area, 5=least deprived area).

Table 5-5: Index of Multiple Deprivation (IMD) of the respondents and non-respondents

Respondents	Quintile of IMD					
	1	2	3	4	5	Total
Non-respondents	123	113	104	110	132	582
Respondents	28	25	31	31	50	165
Total	151	138	135	141	182	747
Pearson chi2(4) = 5.5				Pr = 0.2		

5.3.2 RAND Arabic SF-36

Scoring of SF-36 health questionnaire items of all respondents showed a mean score between 50.4 (energy/fatigue) and 85 (physical functioning), with 0 and 100 representing the least and most favourable health state (Table 5-6). Scores of SF-36 items were found to be lower among abused women compared to the non-abused. Scores of SF-36 items were only provided for participants with severe combined abuse and emotional abuse and/or harassment as there was enough number of abused women compared to other types of abuse (Table 5-7)

Respondents scored below the general Saudi population average in seven of the items of the SF-36 scale except the physical functioning. In all sub-scales of SF-36, my participants scored lower than the UK and US populations average (Figure 5-4).

Table 5-6: All participant's Scores of the eight items of the SF-36 Health survey

Variable	Obs	Mean	Std. Dev.	Min	Max
Physical Functioning	158	85	17	15	100
Role limitation due to physical health	157	73	37	0	100
Role limitation due to emotional problems	157	52	43	0	100
Energy/Fatigue	158	50.4	19	0	100
Emotional well-being	158	61.5	20	16	100
Social functioning	157	69.5	25.3	0	100
Pain	158	71.5	24	0	100
General Health	158	67.5	16	10	100

Obs= No of participants

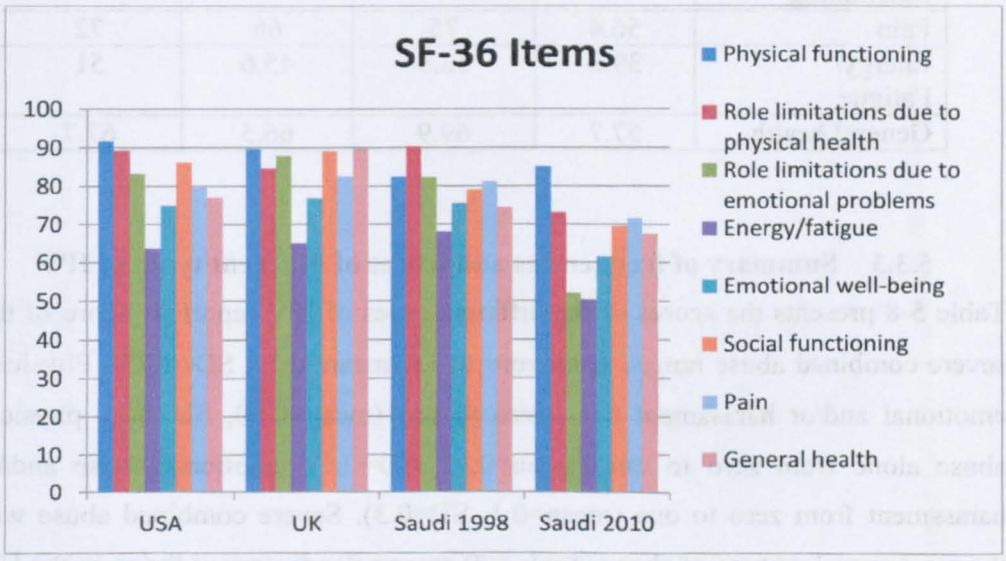

Figure 5-4: comparative graph of SF-36 sub-scale average scores in the US, UK, Saudi 1998, and Saudi population in the current thesis

Table 5-7: Mean scores of SF-36 items in the abused and non-abused women

SF-36 items (mean)	Severe combined abuse		Emotional abuse and/or harassment	
	Yes=30	No= 128	Yes=17	No= 141
Physical functioning	77.4	86.5	87.4	84.5
Role limitation due to physical health	48.3	78.7	67.6	73.6
Role limitation due to emotional problems	31	57	39	53.6
Emotional well-being	47	64.9	54.6	62.3
Social functioning	56	72.5	66.9	69.7
Pain	56.4	75	66	72
Energy/ Fatigue	39.8	52.9	45.6	51
General health	57.7	69.9	66.5	67.7

5.3.3 Summary of frequencies and scores of different types of IPV

Table 5-8 presents the scores of the different types of IPV reported. Score of the severe combined abuse ranged from zero to 15 (mean=0.59, SD=1.75), Physical, emotional and/or harassment from zero to one (mean=0.03, SD=0.2), physical abuse alone from zero to one (mean=0.02, SD=0.1), emotional abuse and/or harassment from zero to one (mean=0.1, SD=0.3). Severe combined abuse was the most prevalent type of abuse (Table 5-8) among Saudi women living in the UK (**19%**, 95% CI: 12.7-24.8), followed by emotional abuse and/or harassment (**11%**, 95% CI: 5-15). Physical abuse alone was the least prevalent type of abuse among these women (**2%**, CI: 1.95-4), followed by physical, emotional and/or harassment (**3%**, CI: 2-4). The standard errors (SE) of the estimates of all types IPV were very small and this indicated that these estimates were precise. SE is a

measure that provides how far the true value in the population the sample estimate is likely to be [251].

Table 5-8: IPV among Saudi women living in the UK

IPV types (independent experiences)	Obs	Mean	Median	Std. Dev	SE (mean)	Min	Max	Frequency	Percentage	CI
Severe-combined abuse	160	0.6	0	1.75	0.1	0	15	30/160	19%	13-25
Physical, emotional and/or harassment	160	0.03	0	0.2	0.01	0	1	5/160	3%	1-5
Physical abuse alone	160	0.02	0	0.1	0.01	0	1	3/160	2%	2-4
Emotional abuse and/or harassment	160	0.1	0	0.3	0.02	0	1	17/160	11%	5-15

The histogram below (Figure 5-5) showed the distribution of different types of abuse, which was positively skewed. This indicated that the bulk of the cases of abuse were to the left of the mean. Hence, to give an accurate picture of the central tendency of the value of the different IPV scores, I used the median measure of central tendency as it will not be affected, like the mean, by the skewed or outliers' values (see Figure5-6 for the box plots showing the median of each type of IPV).

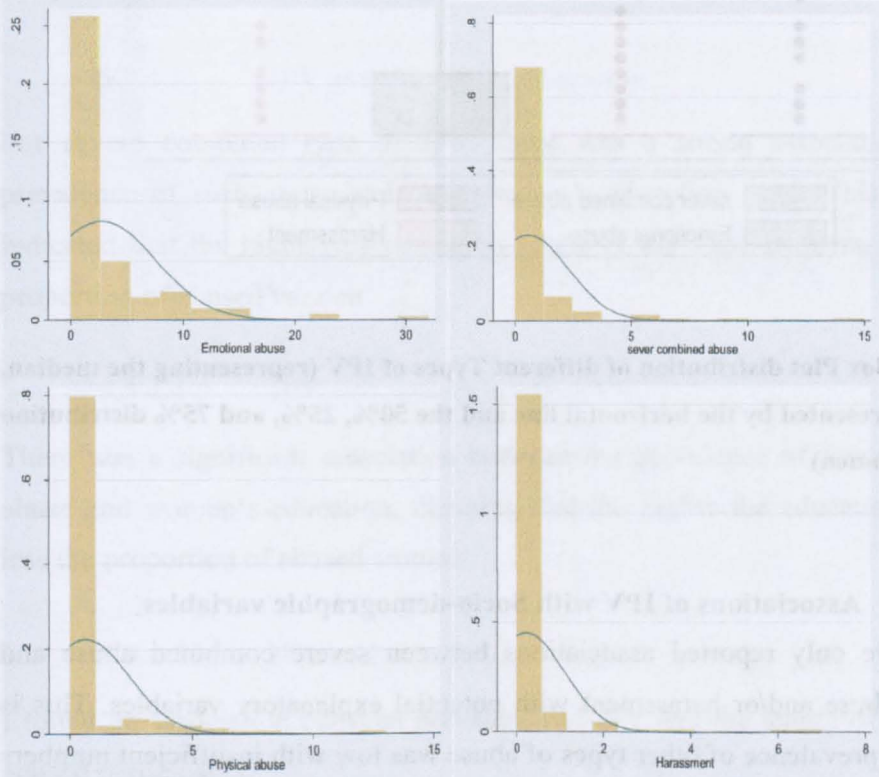

Figure 5-5: Histogram of the distribution of different types of IPV

Note: Density in the Y-axis of the above graphs represents the density of the number of abused women

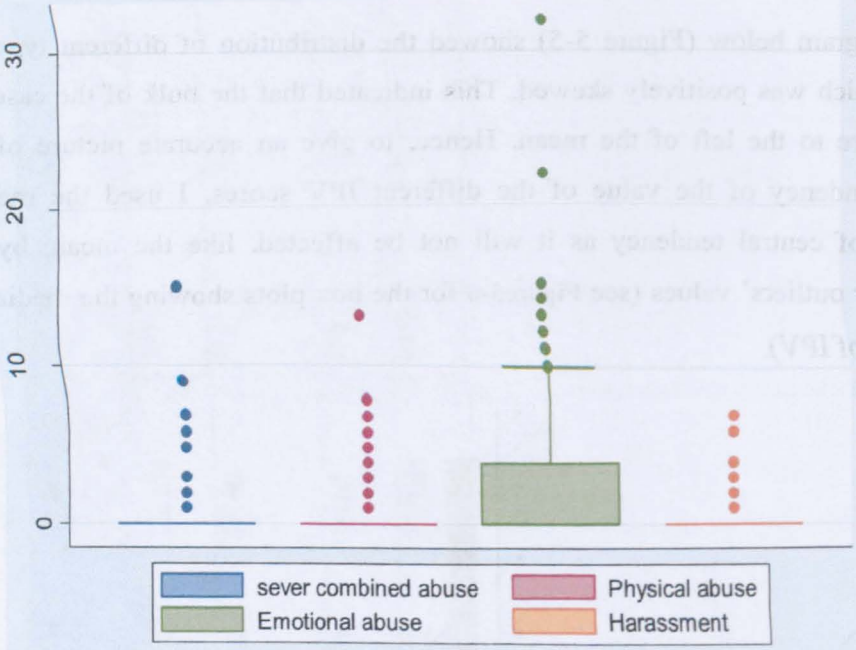

Figure5-6: Box Plot distribution of different Types of IPV (representing the median, which is represented by the horizontal line and the 50%, 25%, and 75% distribution of abused women)

5.3.4 Associations of IPV with Socio-demographic variables

Here, I have only reported associations between severe combined abuse and emotional abuse and/or harassment with potential explanatory variables. This is because the prevalence of other types of abuse was low with insufficient numbers of participants to test for associations. The Chi-square test was used to assess the significance of possible associations of severe combined abuse and emotional abuse and/or harassment with the various socio-demographics of Saudi women living in the UK (Appendix 12). Associations of different types of IPV and socio-demographic factors included the following:

5.3.4.1 IPV and Number Of children

There was a weak association between the numbers of children (≥ 3 children) women have and the prevalence of emotional and/or harassment type of IPV, however, not statistically significant (*P*=0.06).

5.3.4.2 IPV and age of participants

There was a weak association between emotional and/or harassment type of IPV and participant's age groups, but not statistically significant (*P*=0.07).

5.3.4.3 IPV and participant's education

For severe combined type of IPV, there was a strong association between prevalence of such abuse and male partner's education level. This association indicated that the higher the education levels of the male partners, the less the proportion of abused women.

5.3.4.4 IPV and women's education

There was a significant association between the prevalence of severe combined abuse and women's education, denoting that the higher the education level, the less the proportion of abused women.

5.3.4.5 IPV and years of marriage

I found no association between prevalence of IPV and the length of marriage of abused participants.

5.3.4.6 IPV and duration of residence in the UK

There was no association between IPV and the length of stay in the UK.

5.3.4.7 Consequences of IPV (fear)

There was a significant association between the prevalence of severe combined type of IPV and the women's fear from their partners in the current and previous lifetime.

5.3.5 Associations between types of IPV and Health Status

Here, SF-36 items were considered the dependent variable while the prevalence of IPVs as the independent variable, in order to explore the possible association between health status score and prevalence of IPV. Using Chi-square test, participants who were exposed to severe combined abuse had significantly lower score in all items of SF-36 survey compared to non-abused women (Appendix 13).

5.3.6 Regression Model Results

To test the strength of the above associations between various types of IPV and other explanatory variables of significance, logistic regression is the appropriate analysis method to look at these relationships simultaneously and to determine the independent factors that significantly associated with IPV. This allowed estimating the contribution of the factors such as participants' age, number of children, partner education, women education, years of marriage, and time in the UK, to the prevalence of different types of IPV. These factors reflect also the elements of the competing theories (detailed theoretical ecological framework in chapter 3) in which there are several possible explanations for the relationship among a number of explanatory variables.

Since the main outcome variable is binary (abused or non-abused) and there was more than one independent variable (categorical), logistic regression analysis was used. When using the logistic uni-variable regression model, statistically significant associations were found between partner education, women education, and participants' fear of partner, and the prevalence of severe combined abuse (Table 5-9 below). This denoted that in women married to partners with lower education level (secondary and high school), the odds of experiencing IPV was 4.4 times as great as for women married to partners with higher education level (post-graduate). In emotional abuse and/or harassment, there was a significant association only with the factor that women were having ≥ 3 children (Table 5-10 below)

When using the logistic multi-variable regression model controlling for potential confounders, partners' education factor remained significantly related to the

prevalence of severe combined abuse, while women 'education was not significant.

Similarly, uni-variable regression analysis of the score of SF-36 items (dependent variable) with ***severe combined*** type of IPV revealed a significant relationship in all the items, denoting that the prevalence of severe combined abuse was significantly associated with decrease in bio-psycho-social functions. However, only lower score of emotional well-being item of the SF-36 was significantly related to ***emotional abuse and/or harassment*** (Table 5-11).

Multi-regression analysis of the score of SF-36 items (except the physical and social functioning items) revealed also significant association with severe combined abuse after adjusting for all other covariates listed in the table below (Table 5-12). However, multi-regression of the score of SF-36 items showed no association with emotional abuse and/or harassment after adjusting for all factors (Table 5-13), (see further discussion of the implications of these findings in chapter 7).

5.3.7 Conclusion

This chapter provides the prevalence and severity of various types of IPV among Saudi women in the UK. It also presents significant associations of IPV with some of the socio-demographic profiles and health status of abused women. The severe combined abuse is the most prevalent type of IPV among Saudi women living in the UK. Multi-regression analysis showed that socio-demographic factors were not significantly associated with IPV (except partners' education) and this might be due to the low sample size of my survey. Prevalence of severe combined abuse was significantly associated with lower bio-psycho-social functioning, and these associations remained significant after adjusting for potential confounders. I will discuss and integrate these results in detail with the qualitative interviews findings in chapter 7.

Table 5-9: Summary of logistic regression analysis of IPV (*Severe combined abuse*) and other factors

Factors	Severe Combined Abuse **Yes**	Severe Combined Abuse **No**	Univariable OR	SE	P	CI	Multivariable OR	P	CI
Age:18-29	11	52	1				1		
30-50	10	50	0.9	0.4	0.9	0.4 to 2.4	0.5	0.6	0.03 to 7.4
Women with<3 children	16	66	1				1		
Women with≥3 children	17	64	1.3	0.6	0.5	0.6 to 3	0.7	0.7	0.03 to 9.8
Partner's education: *Postgraduate	9	56	1				1		
*Bachelor	11	37	1.8	0.9	0.2	0.7 to 4.9	5	0.09	0.3 to 16.5
*≤High school	9	7	8	4.9	***<0.01***	2.3 to 27	47.7	***0.02***	1.8 to 191
Women's education: *Postgraduate	16	81	1				1		
*Bachelor	6	40	1.7	1.6	0.6	0.3 to 2.1	1.2	0.8	0.3 to 16.5
*≤High school	8	5	46	55.9	***0.02***	4 to 494	6.5	***0.03***	1.4 to 292
Years of marriage: 0-9	10	55	1				1		
10-19	12	32	2.1	1	0.1	0.8 to 5.3	4.5	0.2	0.1 to 59
20-32	6	14	2.4	1.4	0.2	0.7 to 7.6	2.2	0.7	0.01 to 146.9
Time in the UK: *0-1.9	13	40	1				1		
*2-4.9	7	51	0.4	0.2	0.1	0.2 to 1.2	0.3	0.2	0.01 to 1.8
*5-45	5	20	0.7	0.5	0.7	0.2 to 2.5	1.6	0.7	0.04 to 14
Currently afraid from partner: No	14	86	0.1	0.04	***<0.01***	0.02 to 0.2	0.04	***0.02***	0.01 to 0.6
Yes	13	5							

Table 5-10: Summary of logistic regression analysis of IPV (*Emotional abuse and/or harassment*) and other factors

Factors	Emotional abuse and/or harassment **Yes**	Emotional abuse and/or harassment **No**	Uni-variable OR	SE	P	CI	Multivariable OR	P	CI
Age:18-29	4	59	1				1		
30-50	10	50	2.9	1.8	0.1	0.9 to 10	5	0.1	0.7 to 33.6
Women with<3 children	12	67	1				1		
Women with≥3 children	5	76	0.4	0.2	0.1	0.1 to 1.1	0.1	*0.03*	0.1 to 0.8
Partner's education: *Postgraduate	7	58	1				1		
*Bachelor	8	40	1.7	0.9	0.4	0.6 to 4.9	1.2	0.8	0.3 to 5.3
*≤High school	2	14	1.2	1	0.8	0.2 to 6.3	0.5	0.6	0.04 to 6.3
Women's education: *Postgraduate	11	86	1				1		
*Bachelor	5	41	1	0.5	0.9	0.3 to 2.9	1.1	0.9	0.2 to 6.1
*≤High school	1	12	0.7	0.7	0.7	0.1 to 5.5	0.9	1	0.1 to 12.8
Years of marriage: 0-9	7	58	1				1		
10-19	9	35	2.1	1.2	0.2	0.7 to 6.2	4.2	0.1	0.6 to 28.2
20-32	1	19	0.4	0.5	0.5	0.1 to 3.8	1.8	0.7	0.1 to 33
Time in the UK: *0-1.9	5	48	1				1		
*2-4.9	8	50	1.5	1	0.5	0.5 to 5	0.6	0.5	0.1 to 3.2
*5-45	4	21	1.8	1.3	0.4	0.4 to 7.5	0.5	0.5	0.1 to 4.3
Currently afraid from partner: No	2	85	1						
Yes	15	16	1.4	1.1	0.7	0.3 to 6.8	0.5	0.6	0.1 to 4.5

Table 5-11: Uni-variable Regression analysis of SF-36 items with IPV

SF-36 Items	Severe combined abuse			Emotional abuse and/or harassment		
	Coef.	P	95% CI	Coef.	P	95% CI
Physical functioning	-0.5	*0.01*	-0.9- to -0.1	0.1	0.8	-0.5 to 0.6
Role limitation due to physical health	-0.9	*<0.01*	-1.3 to 0.5	-0.3	0.2	-0.8 to 0.1
Role limitation due to emotional problems	-0.7	*<0.01*	-1.1 to -0.3	-0.4	0.1	-0.9 to 0.1
Emotional well-being	-0.9	*<0.01*	-1.3 to -0.5	-0.6	*0.02*	-1.1 to -0.1
Social functioning	-0.7	*<0.01*	-1.1 to -0.3	-0.3	0.3	-00.8 to -0.2
Energy/Fatigue	-0.7	*<0.01*	-1.1 to -0.4	-0.4	0.1	-0.9 to 0.1
Pain	-0.8	*<0.01*	-1.2 to -0.4	-0.4	0.1	-0.9 to 0.1
General Health	-0.8	*<0.01*	-1.2 to -0.4	-0.2	0.3	-0.7 to 0.3

Table 5-12 Multi-regression analysis of the association between SF-36 items and *Severe Combined Abuse (SCA)* adjusted for other confounders

IPV adjusted for confounders	SF-36 Items																							
	Physical functioning			Role limitation due to physical problem			Role limitation due to emotional problem			Emotional well being			Social functioning			Pain			General health			Energy/fatigue		
	Coef	P	CI	Coef	P	CI	Coef	P	CI	Coef	P	CI	Coef	P	CI	Coef	P	CI	Coef	P	CI	Coef	P	CI
Severe combined abuse	-0.5	0.2	-1.3 to 0.3	-0.8	*0.03*	-1.5 to 0.1	-0.9	*0.02*	-1.6 to 0.1	-0.8	*0.03*	-1.4 to -0.1	-0.4	0.2	-1.2 to 0.3	-0.9	*0.01*	-1.8 to -0.2	-0.8	*0.04*	-1.5 to -0.02	-1	*0.01*	-1.7 to -0.2
Age: 18-29																								
30-50	-0.5	0.1	-1.2 to 0.2	-0.7	*0.02*	-1.4 to 0.1	0.02	0.9	-0.6 to 0.7	-0.1	0.6	-0.8 to 0.5	-0.1	0.7	-0.8 to 0.5	-0.4	0.3	-1 to 0.3	-0.2	0.5	-0.9 to 0.4	-0.1	0.7	-0.8 to 0.5
Years/marriage:																								
0-9																								
10-19	0.04	0.9	-0.7 to 0.8	0.7	*0.04*	0.01-1.4	-0.7	0.06	-1.4 to 0.01	-0.6	0.06	-1.3 to 0.1	-0.5	0.1	-1.2 to 0.2	-0.4	0.2	-1.2 to 0.3	-0.2	0.6	-0.9 to 0.5	-0.1	0.7	-0.8 to 0.6
20-32	-0.1	0.9	-1.2 to 1.1	0.5	0.4	-0.6 to 1.5	-0.3	0.6	-0.3 to 1.8	-0.9	0.08	-1.9 to 1	-0.3	0.6	-1.3 to 0.7	0.9	0.1	-2 to 0.2	-0.4	0.5	-1.5 to 0.7	-0.1	0.9	-1.2 to 1
<3 children																								
≥3 children	0.01	1	-0.7 to 0.7	-0.1	0.7	-0.8 to 0.5	0.7	*0.04*	0.02 to 1.3	0.8	*0.01*	0.2 to 1.4	0.4	0.2	-0.2 to 1	0.5	0.2	-0.2 to 1	0.1	0.7	-0.5 to 0.8	0.4	0.2	-0.2 to 1
Time/UK:																								
*0-1.9																								
*2-4.9	0.4	0.2	-0.2 to 1	0.5	0.1	-0.1 to 1	-0.3	0.3	-0.9 to 0.3	-0.1	0.8	-0.6 to 0.5	-0.1	1	-0.6 to 0.6	0.5	0.1	-0.1 to 1	-0.02	0.9	-0.6 to 0.6	-0.5	0.1	-1 to 0.1
*5-45	0.6	0.1	-0.2 to 1.4	0.4	0.2	-0.3 to 1.2	-0.02	1	-0.8 to 0.7	0.1	0.9	-0.6 to 0.7	0.6	0.1	-0.1 to 1.3	0.8	*0.04*	0.04 to 1.6	0.2	0.7	-0.6 to 0.9	-0.3	0.4	-1 to 0.5
Partners' education:																								
*Postgraduate																								
*Bachelor	0.5	0.1	-0.1 to1	0.1	0.6	-0.4 to 0.6	-0.1	0.7	-0.6 to 0.4	0.1	0.5	-0.3 to 0.6	0.1	1	-0.5 to 0.5	0.5	0.08	-0.1 to 1	0.2	0.4	-0.3 to 0.7	-0.02	0.9	-0.5 to 0.5
*≤High school	0.4	0.3	-0.4 to1.3	0.4	0.3	-0.4 to 1.2	0.1	0.9	-0.9 to 0.8	-0.2	0.5	-0.9 to 0.5	-0.2	0.7	-0.9 to 0.6	0.6	0.2	-0.3 to 1.4	-0.3	0.5	-1 to 0.6	-0.3	0.4	-1 to 0.5
Women' education:																								
*Postgraduate																								
*Bachelor																								
*≤High school	-0.3	0.4	-0.9 to 0.3	-0.2	0.4	-0.8 to 0.3	0.03	0.9	-0.5 to 0.6	0.1	0.6	-0.4 to 0.7	-0.1	0.6	-0.7 to 0.4	0.03	0.9	-0.6 to 0.6	0.2	0.6	-0.4 to 0.7	0.2	0.6	-0.4 to 0.7
	0.4	0.4	-0.5 to 1.3	0.01	1	-0.9 to 0.9	0.1	0.9	-0.8 to 0.9	0.1	0.8	-0.7 to 0.9	-0.3	0.5	-1 to 0.6	0.5	0.3	-0.5 to 1.4	-0.02	1	-0.9 to 0.8	-0.3	0.5	-1.2 to 0.6
Currently afraid from partner:																								
No	0.3	0.5	-0.6 to 1.2	0.4	0.3	-0.4 to 1.2	0.1	0.8	-0.7 to 0.9	0.6	0.1	-0.1 to 1.4	0.5	0.2	-0.3 to 1.3	-0.1	0.7	-1 to 0.7	-0.6	0.2	-1.4 to 0.2	0.1	0.9	-0.8 to 0.9
Yes																								

Table 5-13: Multi-regression analysis of the association between SF-36 items and *Emotional abuse and/or harassment* adjusted for other confounders

IPV adjusted for confounders	SF-36 Items																							
	Physical functioning			Role limitation due to physical problem			Role limitation due to emotional problem			Emotional well being			Social functioning			Pain			General health			Energy/fatigue		
	Coef	P	CI	Coef	P	CI	Coef	P	CI	Coef	P	CI	Coef	P	CI	Coef	P	CI	Coef	P	CI	Coef	P	CI
Emotional abuse and/or harassment	0.2	0.6	-0.5 to 0.9	-0.2	0.5	-0.9 to 0.4	-0.06	0.9	-0.7 to 0.6	-0.07	0.8	-0.7 to 0.5	0.1	0.7	-0.5 to 0.7	-0.02	1	-0.7 to 0.7	-0.1	0.7	-0.8 to 0.5	<0.01	1	-0.7 to 0.7
Age: 18-29																								
30-50	-0.5	0.2	-1.2 to 0.2	-0.7	0.06	-1.3 to 0.01	0.06	0.9	-0.6 to 0.8	-0.1	0.7	-0.7 to 0.5	-0.1	0.7	-0.8 to 0.5	-0.3	0.4	-1 to 0.4	-0.2	0.6	-0.9 to 0.5	-0.1	0.8	-0.8 to 0.6
Years/marriage: 0-9																								
10-19	-0.02	1	-0.8 to 0.7	0.7	0.06	-0.02 to 1.4	-0.7	0.06	-1.5 to 0.02	-0.6	0.07	-1.3 to 0.04	-0.6	0.1	-1.3 to 0.1	-0.5	0.2	-1.3 to 0.3	-0.2	0.6	-1 to 0.5	-0.2	0.6	-0.9 to 0.6
20-32	-0.1	1	-1.2 to 1	0.5	0.4	-0.6 to 1.6	-0.3	0.6	-1.4 to 0.8	-0.9	0.1	-2 to 0.2	-0.3	0.6	-1.4 to 0.8	-0.9	0.1	-2 to 0.3	-0.4	0.5	-1.5 to 0.7	-0.1	0.9	-1.2 to 1
<3 children																								
≥3 children	0.1	0.8	-0.6 to 0.8	-0.2	0.6	-0.8 to 0.5	0.7	***0.05***	0.001 to1.4	0.8	***0.01***	0.2 to 1.5	0.5	0.2	-0.2 to 1	0.5	0.2	-0.2 to 1.3	0.1	0.7	-0.6 to 0.8	0.5	0.2	-0.2 to 1.2
Time/UK: *0-1.9																								
*2-4.9	0.5	0.1	-0.1 to 1	0.6	0.06	-0.01 to 1	-0.2	0.6	-0.8 to 0.4	0.03	1	-0.5 to 0.6	0.1	0.8	-0.5 to 0.6	0.7	***0.04***	0.03 to 1.3	0.1	0.8	-0.5 to 0.7	-0.3	0.3	-0.9 to 0.3
*5-45	0.7	0.1	-0.1 to 1.5	0.5	0.2	-0.3 to 1.2	-0.0	1	-0.8 to 0.8	0.1	0.9	-0.6 to 0.8	0.6	0.1	-0.1 to 1.3	0.9	***0.04***	0.03 to 1.7	0.2	0.7	-0.6 to 0.9	-0.3	0.5	-1 to 0.5
Partners' education: *Postgraduate																								
*Bachelor	0.4	0.1	-0.1 to 1	0.1	0.8	-0.5 to 0.6	-0.2	0.5	-0.7 to 0.4	0.1	0.7	-0.4 to 0.6	-0.03	0.9	-0.5 to 0.5	0.4	0.2	-0.2 to 1	0.2	0.6	-0.4 to 0.7	-0.1	0.7	-0.6 to 0.4
*≤High school	0.3	0.5	-0.5 to 1	0.1	0.8	-0.7 to 0.9	-0.4	0.3	-1 to 0.4	-0.5	0.2	-1.3 to 0.2	-0.3	0.4	-1 to 0.4	0.2	0.7	-0.7 to 1	-0.6	0.2	-1.4 to 0.2	-0.7	0.1	-1.5 to 0.1
Women' education: *Postgraduate																								
*Bachelor	-0.3	0.3	-1 to 0.3	-0.3	0.3	-0.9 to 0.3	-0.02	0.9	-0.6 to 0.6	0.1	0.8	-0.5 to 0.6	-0.2	0.5	-0.7 to 0.4	-0.03	0.9	-0.7 to 0.6	0.1	0.7	-0.5 to 0.7	0.1	0.8	-0.5 to 0.7
*≤High school	0.2	0.6	-0.7 to 1	-0.3	0.5	-0.1 to 0.6	-0.2	0.6	-1 to 0.6	-0.2	0.7	-1 to 0.6	-0.4	0.3	-1.3 to 0.4	0.1	0.8	-0.8 to 1	-0.3	0.5	-1.2 to 0.6	-0.7	0.1	-1.6 to 0.2
Currently afraid from partner:																								
No	0.5	0.2	-0.3 to 1.3	0.7	0.06	-0.02 to 0.5	0.5	0.2	-0.3 to 1.3	1	***0.01***	0.2 to 1.7	0.7	0.08	-0.1 to 1.4	0.3	0.5	-0.6 to 1	-0.3	0.5	-1 to 0.5	0.5	0.2	-0.3 to 1.3
Yes																								

Chapter 6. IPV experiences of Saudi women in the UK

6.1 Introduction

This chapter discussed the methods and results of the qualitative interviews study that was conducted after the survey (previous chapter). The survey was conducted to answer the prevalence of IPV question, and this qualitative interview study was conducted to explore Saudi women's experiences of such violence.

When researching subjective experiences, people cannot be viewed separately from the multiple influences that have constructed their reality, such as culture, personal values, beliefs, social, economic, and political contexts [252]. These influences can be explored using an in-depth qualitative method that allows for the exploration of the subjective experiences of women exposed to IPV. The choice of qualitative study was also based on the concept that IPV is a multi-dimensional public health problem that carries factors influencing multiple spheres of women's life at various levels (individual, partnership, familial, societal spheres described in the theoretical framework chapter). These factors can be explored as numbers, ratio or percentage, as it was conducted in the survey. However, some of these indicators have a purely descriptive function that may take into account the changing trends in the social and cultural contexts of Saudi women who have been exposed to IPV, but do not allow for an investigation of women's experiences of IPV. Exploring Saudi women experiences and views about IPV possibly allowed me to unpack some of the contexts of the experiences, re-construct previously known concepts of IPV and pay attention to new ones not attended so far in similar, or even, different cultures. For example: the influence of religion on women's decision to stay or leave their partners in Muslim communities generally and in Arab culture, in particular.

Understanding the women's perspectives was important to complement and illuminate the possible findings and recommendations that could be stemming from the survey study. For example, if there were noticeable low prevalence of

sexual, physical or emotional violence, it would be further explored by interviewing the women to find their views and understanding of which acts are considered abuse. Such views and understandings might influence how the women respond to the survey questions by interpreting the question differently to how the researcher intended.

Semi-structured in-depth interviews were used in this study to collect data as they can investigate the complexity of IPV by exploring the women's understanding of the nature, meanings and interpretations that could surround the experience of IPV [253].

6.2 Method

To date, various qualitative methods have been used to explore women's experiences exposed to IPV such as focus groups discussions and face-to-face interviews. One of the most widely used methods is the face-to-face semi-structured interview [254]. This strategy is especially well suited to the objective of this study because one of its principal strengths is the flexibility that allows for in-depth examination of understandings of subjective experiences and exploration of the dimensions involved in IPV occurrence (religious, cultural and societal dimensions). The one-to-one nature of the interview was important as it allowed building trusting relationship, which was essential due to the sensitive nature of the subject.

6.2.1 Sampling

Women were purposefully sampled (maximum variation sampling) using the socio-demographic information women provided in the survey before the interview. This was done to ensure interviews were conducted with a heterogeneous sample of Saudi women in regard to: different age, socio-demographic background, area of residence, time in the UK and disclosure to different types and severity of violence, in an attempt to capture the diverse experiences of IPV among Saudi women.

In the survey, women were asked at the end to tick a box indicating if they were willing to be interviewed. Women who agreed to be interviewed were tabulated describing their age, area of resident, type and severity of violence in order to be

considered for selection. Women were included if they were currently or had been in an intimate partner relationship and exposed to violence from their partners sometime in their life. Women were excluded if they have never been in an intimate relationship, and those who were scored and labelled as non-abused. The number of women needed to be interviewed was determined by the need to achieve data saturation when no new themes were emerging from the data by the end of data collection [255].

6.2.2 Recruitment

I contacted women who indicated that they were willing to be interviewed and who were sampled for the qualitative interviews stage, by telephone to discuss the purpose of the interview further. If the woman was still willing to take part, an interview was arranged at a time and place that was convenient for her. The reason why I chose to only interview those who indicated in the survey that they were abused was based on trusting results of survey in defining abused women. I sampled women who scored positive on the CAS, as I wanted to explore in the interviews women's experiences of IPV. Hence, I used the CAS results to identify women who might have experienced IPV. However, there could be a possibility that either CAS can miss abused cases as some women did not want to declare their abuse or it might not reflect their status of abuse in their contextual situation. This is because CAS has been invented in English with a Western cultural context, which is different from Saudi culture in terms of beliefs, definitions and perspectives of IPV (see further detail in the discussion chapter, section 7.4.4.1).

6.2.3 Conducting the interviews

Interviews followed a semi-structured format, with broad areas being similar across all interviews but with responsive follow-up and probing questions used to aid clarification in individual interviews. Bowling pointed out that in-depth interviewing that attempts to be more conversional and engaging requires skill and experience [243]. As a researcher and being part of the research tool in conducting the interviews, collecting and analyzing the data, I had to have the understanding and skills in order to engage with the participants to explore their IPV experiences. Hence, I had training (attended qualitative research methodology

course and qualitative interviews skills course) on how to conduct ***research interviews***, which were different to the ***clinical interview*** skills I already had as a General Practitioner (ten minutes consultation).

A topic guide was used in order to assist questioning during in-depth interviews. The topic guides, devised to guide, but did not dictate data collection, incorporated considerable flexibility to allow participants to introduce new issues unanticipated by the researcher. The topic guide contained six topics (Appendix 14). At the beginning, background questions were used to establish rapport and to make the interview as comfortable as possible, such as: tell me a bit about yourself? How long you have been in the UK? The second topic involved questions to explore women's experiences of violence, but with an open-ended manner, for example, this stage of the interview started with the question: tell me how your relationship with your husband has developed/changed over the years? in order to prompt for possible reasons for any changes. Questions were developed to obtain the chronological sequences of violence acts, and the associated factors that women think contributed to such acts, place them in the same context in which they occurred, and derive explanations that are strongly based in the socio-cultural reality of Saudi women.
The third topic explored the mechanism women used to ask for help. The fourth topic explored the effect of abuse on women physically, psychologically or socially. The fifth one developed to understand women's views about discussing IPV publically in society (including use of the media) or as a private issue that needs to be discussed between partners or their families privately. The last topic explored the beliefs women held about leaving or staying with their partners who abused them in the context of their culture and religion. The final question was an invitation for women to raise any other points they considered to be relevant. Additionally, women were asked of what they think of the survey and or the interview reflecting on their feelings and views.

Probing follow-up questions were asked on topics that have been raised encouraging women to provide more details, and provide clarification, such as: Can you tell me a little more about this? Emerging areas of interest were explored

in later interviews by the technique of starting a new topic providing examples from previous interviews, for example: some women I interviewed told me that their family might have a role in the occurrence of IPV, what is your view in this matter? Pauses were taken during data collection to conduct analysis. Data analysis was ongoing and iterative (revising the topic guide questions as the study progressed, in the light of information gleaned along the way). This was done in order to include or investigate new emerging topics women had raised and explore further in later interviews. These topics were discussed with my supervisor (Dr. Jeremy Horwood) for the feasibility and appropriateness of including them. Thereafter, the topic guide was modified accordingly to involve the new emerging areas of interest. For example: if partners are relatives and how this might affect the relationships in relation to IPV. These issues raised by some participants were adopted, and the topic guide was modified consequently to be explored in future interviews.

Interviews were conducted in the language of the women's choice. The majority were in Arabic (thirteen participants), while a few were in English (seven participants), although occasionally the participants spoke in Arabic or English. Some women found it sometimes easier to express their views or feelings in English or Arabic depending on the length they had been stayed in the UK. The women were given the choice of either conducting the interview face-to-face or via the telephone.

At the end of interview, women were thanked and reassured about confidentiality of the information they gave and were given £10 vouchers as a reimbursement for sharing their experiences.

6.2.4 Ethical issues

Participants were fully informed of the aims of the study and of the requirements of taking part in the study in the information sheet sent with the postal survey (Appendix 11). Participants were reminded before commencing the interview that they may decline to answer any question, or to withdraw from the study at any time, without having to give a reason for doing so. Women were provided with

support if the interviews raised some issues for them by referring them to the help resources in the information sheet provided.

Written informed consent was obtained at the time of the interview (Appendix7) for women interviewed face-to-face. Women who were interviewed by telephone were sent the consent before the scheduled time of the interview and asked to send it back one day before the telephone call. Before starting the interview by the telephone, women were asked if they understand each statement of the consent and whether they needed more clarification. With the participant's consent, the interviews were audio-taped, transcribed and anonymised. The transcribed interviews were translated immediately into English. The first two interviews were double translated by the researcher and an independent external professional translator to check for accuracy and consistency of the translation. To ensure the confidentiality of participants, all audio files and transcripts, were stored securely on password-protected computers at the University.

6.2.5 Safety issues

The first and overriding issue in IPV research must be safety and confidentiality. Qualitative research focusing on abused women must be designed with procedures that ensure the physical safety and the confidentiality of the women participating and the researchers. An abusive partner's discovery of a woman's participation in research was a risk common to most of the abused women and could put women at considerable threat for retaliatory violence.

Procedures for safely contacting participants, ensuring safety for those being interviewed, acknowledging the limitations of confidentiality, and securing the data were identified as key areas in safety protocols for research involving abused women [256]. In the current study, threats to women's safety addressed through the development of a safety protocol, such as the one modified by David R. Langford which I followed in my present study [257].

Knowing the study population, actually being part of them, is the first step in identifying potential safety issues in the study design. The preparatory work of becoming sensitive to the possible risks to women's safety is a process called developing theoretical sensitivity [258]. Therefore, this preparatory work was

obtained by recognizing my study population's contexts and the inherited insight of the Saudi culture. This work and in addition to the literature and the effort in discussing the safety issues with my supervisors, were parts of the theoretical sensitivity needed in designing the study. This discussion also raised my awareness of my own safety as well as those of the participants.

When women were contacted to arrange an interview time and place, they were asked if it was safe to talk to them and if not, the choice was to call back when it was more convenient. Several women who consented to be interviewed were difficult to contact partially because of their work or other social commitments. In most cases, it took weeks to book an interview, and leaving a voice message was an option, but there was a risk where anyone could access the messages. Additionally, I used a call-in form with instructions that I followed to ensure my safety as a researcher when interviewing women during or after the office working hours (Appendix 15). This call-in form was an addition to the research protocol. It outlined the steps taken to address potential threats to the physical safety of participants and myself. Within the safety protocol, conditions were defined under which I should terminate an interview due to for example the husband appeared in the middle of the interview process.

Furthermore, it was a routine to discuss the safety of myself before the interviews with my supervisors in our meetings. Moreover, I had frequent debriefing sessions after interviews with my supervisors, who also provided access to a professional counsellor. However, I did not ask for help from the counsellor as I had enough support from my supervisors discussing issues related to my feelings and any other effects that resulted from the interviews.

6.2.6 Analysis

My approach to data analysis reflected Lister's concern that highlighted the importance of being both fair to the participants' account and connecting to the theoretical contest in the field of IPV:

> *To do justice to participant's account and, at the same time, engage in the theoretical debate in the field.(p.126) [259]*

IPV theories, including the ecological framework, which I discussed in the theoretical chapter (3), were used to *inform* and *structure* my thesis and not to be a prior theory defining the analysis. This allowed me to engage in some of the IPV theoretical debate as Lister reflected in his concern above. Furthermore, IPV theories discussed (Chapter 3) informed me that IPV involved multiple dimensions: individual, family, and society. In addition, these theories provide several elements of the topic guide that should be included in the interview study of my thesis.

Thematic analysis was used to explore the data, based on an inductive approach using the raw data to develop analytical themes from the experiences and views put forward by the women during the interviews. Inductive approach allowed me to open up the research to any possible factors that might emerge from the interviews as this was the first time such a topic explored among Saudi women. Thematic analysis is a method for identifying, analysing, and reporting on patterns within data. A theme is a pattern that captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set [260]. Thematic analysis has the advantage of being structured yet flexible, and provides a rich and detailed, yet complex, account of data [261]. Additionally, it is a contextual method that could acknowledge the ways women make meaning of their experience and in turn, the ways the broader social context impinges on those meanings.

Data coding involved identification of bits of data that are meaningful in relation to the data understood in context, and through comparisons looking for patterns or variations in the data. The meaning of patterns, categories and themes emerging from the data were evolving during the coding, as more and more decisions were made about which bits of data could be assigned to each category [260].

> *The qualitative analyst's effort at uncovering patterns, themes, and categories is a creative process that requires making carefully considered judgments about what is really significant and meaningful in the data (p. 406) [260]*

Coffey and Atkinson pointed that:

> *Coding can be thought about as a way of relating our data to our **ideas** about these data (p.27) [262]*

In the beginning, I read and re-read the transcripts of the initial five interviews in order to gain an overview of the data, and become thoroughly familiar with the data set. In addition; it facilitated the process of identifying recurring initial ***ideas***. This was carried out by writing preliminary notes in the left hand margins of the transcripts, initial thoughts, and comments. These ideas were coded. Within every transcribed interview, each phrase, sentence and paragraph were read in fine detail in order to decide 'what is this about'. This coding process resulted in a list of ***codes*** that constituted the preliminary initial code frame. Phrases or expressions were retained as much as possible from the participant's own terms when naming codes.

Although I had a set of prior issues, I was aware that I should maintain an open mind, and the data guided the coding. Coding of the data involved also logical and intuitive thinking. It involved making some judgments about meanings, about the importance and relevance of issues, and may be implicit linkages between ideas. Coding involved identification of the parts of the data that correspond with a particular idea. During the interviews, there were occasions when some participants reported on 'other' women's experiences of relationships and violence. These narratives represented a challenge to the process of analysis, and careful consideration was given to how these 'second hand' scenarios should be analysed. It was obvious that the knowledge of other women's experiences had an effect in shaping their perception and understanding. Given the centrality of the Saudi women's perceptions and attitudes to the current project's research focus, I decided to include these perceptions in the data analysis. Perceptions and attitudes from 'other' Saudi women are possibly reflecting the general trend and cultural practices that most Saudi women are facing, in particular, the religious, legal, political, and social practices that are applicable in all Saudi population.

After the initial code frame was developed, I applied it to the rest of the raw data bearing in mind that this frame could be evolving as the transcripts were read. A process of cross-checking then followed that involved the re-examination of all codes previously generated in order to assess the appropriateness of their labels as well as to discover any overlaps across codes or any that was effectively redundant. The coding frame evolved every time the transcripts were read, and new codes added. The constant comparison technique was used where new codes were applied to the previously coded transcripts to make sure that all the data was considered as the analysis progressed [263].

Inter-connected codes were then clustered together. This yielded a list of what appear to be important ***categories*** within the data. The meanings of categories were bound up on the one hand, with the bits of data to which they were assigned, and on the other hand, with the ideas they expressed [264]. The bits of data that "look alike" and "feel alike" were aggregated if they were related to each other conceptually enough to be categorized in a meaningful manner. Lincoln and Guba emphasized that categorization is to bring together those data bits that apparently relate to the same content [265].

> *Devise rules that describe **category** properties and that can, ultimately, be used to justify the inclusion of each data bit that remains assigned to the category as well as to provide a basis for later tests of replicability (p.347) [265]*

To help manage the data, the thematic analysis was informed using a framework method [266]. Data that informed the categories was charted in a table for each participant to provide an overview of the data. This allowed me to focus on each participant's account in turn so that the detail and distinctions that lied within could be revealed. Additionally, it allowed me to look across all the participants to compare experiences in order to summarize their experiences into a synopsis of presentable data. This also allowed the data to be scrutinised for negative (deviant) cases and reasons for the deviance were explored by comparison with the whole data set. Deviant cases involved discussing the data that did not support or appear to contradict patterns or explanations that emerged from the data. This allowed for refinement, revision, and broadening of the patterns emerging from

the data. Contradictory or deviant cases' analysis was of paramount importance in order to consider all the data in the analysis. These categories were then sorted and grouped under broader '***themes***' identifying links between categories to group them thematically. However, I was aware that this structure was not necessarily permanent and could be changed at a later stage depending on the importance and persistent presence of each code and category within the theme.

Clustering of codes and categories into themes was conducted with an openness and flexibility to perceive and recognize the emerging pattern. Emerging themes were described in terms that stayed close to the language and terms used in the data set. The above process of analysis was described by Boyatzis as a *way of seeing* (thematic analysis) that involved three phases of inquiry: seeing and recognizing something preceding encoding it, which in turn precedes interpretation [260].

Themes were written up using all the codes and categories within each theme with quotes to produce descriptive accounts of what was happening in that theme. These quotes in the descriptive accounts were ordered with similar beliefs, views or experiences together. Using direct quotes from the interviews data strengthened the face validity and credibility of the presented findings and demonstrated the integrity and competence of the results [267]. This was followed by the final stage, which was interpretation that provided associations between findings, explanations, and the nature of IPV (explanatory account below)

Producing explanatory accounts involved finding links or connections between two or more themes. It was a process of exploring associations and particular patterns of behaviours or experiences, even contradictory ones, among Saudi women exposed to IPV. This allowed systematic clustering of themes that are potentially related in a conceptually meaningful manner. For example, two or may be more themes could be linked to explain why women stay/leave their violent

partners. This could be a subjective approach but if linked to previous similar research findings, especially if it comes from the same culture, it would be an acceptable conclusion that could enrich further our understanding to women's experiences of IPV. This linking between themes is in line with my ecological framework, which I will explain in the discussion chapter.

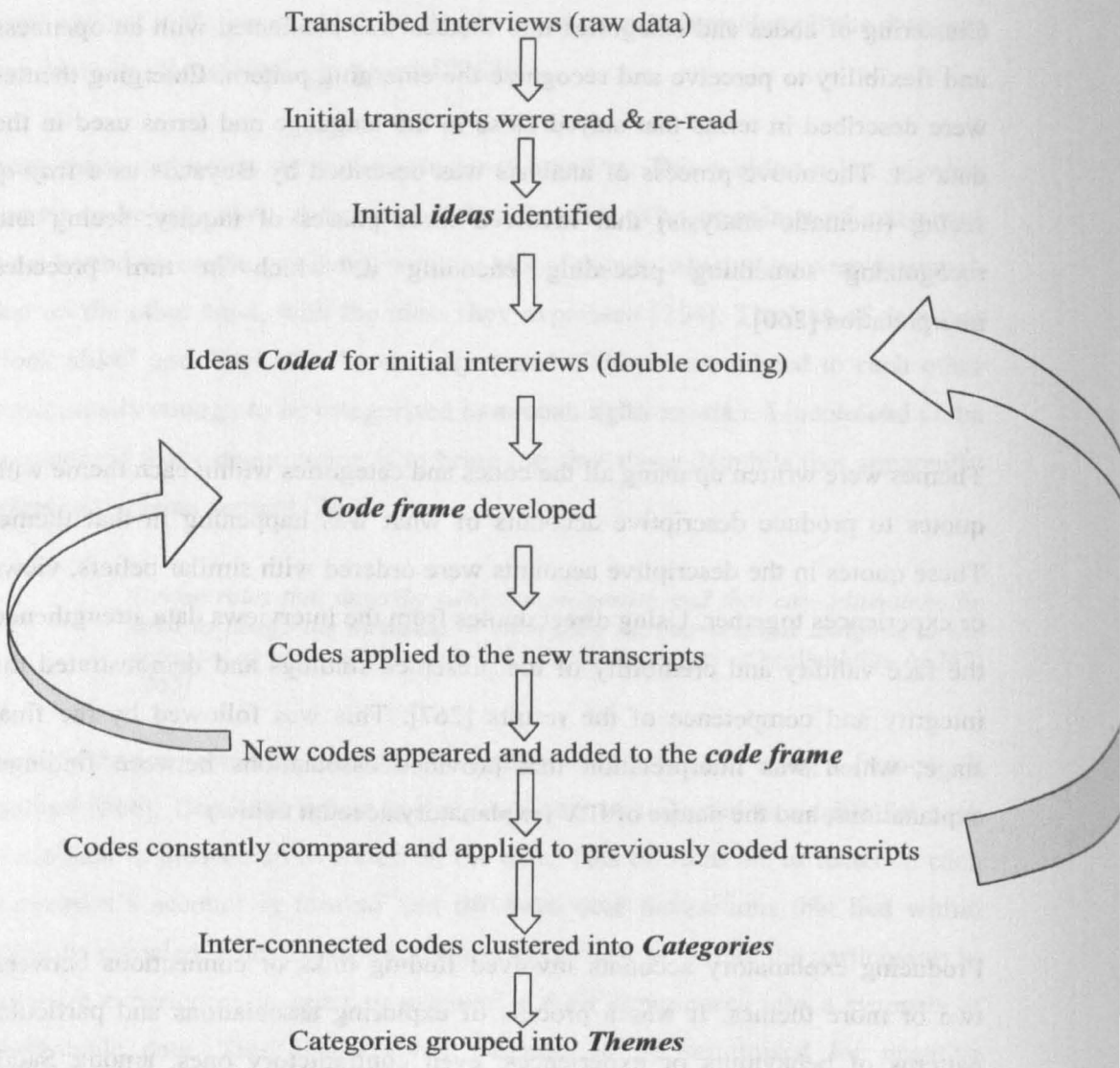

Figure 6-1: Thematic Analysis process

To ensure the robustness of the data analysis, quality measures were undertaken to enhance the validity and reliability of the findings from the interviews. This was done with the help of my supervisor, Dr. Jeremy Horwood, who is an experienced research fellow in qualitative data analysis. The first three interviews were coded in duplicate by me and my supervisor (Dr. Jeremy Horwood) and there were a few inconsistencies that resulted in a more reliable code frame. This frame was revised by both of us on different stages during the coding process to ensure its clarity and systematically compare everyone coding. This resulted in a series of productive debates and reflections between us providing not only a code frame but also more abstracted interpretive themes summarising the experiences of IPV among Saudi women.

Analysis was performed with two main stages involved in its course. The first requires the coding of the data, and the second involves making sense of the evidence through descriptive or explanatory accounts [268]. In addition, I had an ongoing reflective dialogue with my supervisors about the analytic process in order to ensure the quality and rigor of data analysis and description. Furthermore, to prevent a threat to validity and to enhance the rigour within this study, self-awareness and critical reflection by the primary researcher of any personal influences and their effects on the study were considered and discussed in the discussion chapter [269].

6.3 Results

Twenty Saudi women were interviewed. The interview time ranged between 43 minutes to 76 minutes. Sixteen women were interviewed face-to-face in their homes, and four were interviewed by telephone as mutually agreed with the women. The interviews were conducted across the country, including London, Bristol, Bath, Newcastle, Manchester, Leeds and Nottingham. The age of my participants ranged from 24-63 years old, and the mean age was 31±6 years. Participants were heterogeneous in their socio-demographic profile and diverse in their experiences of IPV (Table 6-1). According to CAS scoring, ten of the

interviewed women were emotionally abused (of which two were also exposed to physical IPV); five were physically abused (also emotionally abused), and five were with severe combined IPV (two were exposed to emotional and harassment types of abuse, and three were exposed to emotional, physical and harassment).

The majority of the informants (14 women) were university graduates and reside in the UK to continue their postgraduate studies while a few (six women) were accompanying their partners who were coming after scholarships guaranteed for them. The length of stay in the UK varied between 11 months to 10 years. Marriages in the majority of participants were 'arranged', and only two married were through personal choice. The majority of the participants were in a current marriage relationship (17 women); a few were either divorced or separated (three women). Four women were pregnant at the time of the interview (four women).

The average time elapsed between the survey, and the interview was 4-12 months. This was depending on many factors, for example: time taken to call the women and agreeing on suitable time and place of interview, time taken to receive the survey, analyse the response, scoring of CAS, and selecting women suitable for interviews, and other logistics that were needed to check women's readiness, e.g. safety issue, immediately before conducting the actual interview. At the end of the majority of the interviews, participants expressed a sense of relief and gratitude for having the chance to share their stories. Several informants fed back their views about the survey questionnaire and explicitly provided what they thought of its structure and contents.

The interviews' data provided rich information about the Saudi women's subjective views and experiences of IPV. Clustering of the inter-connected codes to find patterns in women's experiences of IPV yielded important categories, which were grouped forming the themes that represented the results of this chapter (Figure 6-2). The themes were: 1) Being abused: process and progression, 2) Bio-psycho-social impacts, 3) Explaining, understanding and beliefs, 4) Talking matters: silence, sharing and safety, 5) Overcoming challenges, and 6) Sustainability, tolerance, or leaving abusive partners. Themes were explained in

details using quotes as real-life experiences expressed by women during the interviews. A few of the codes in the theme were in vivo words women themselves expressed during the interviews, for example: *No place to go*. I will now outline each theme in turn.

Table 6-1: Interviewed participants' characteristics

Participants	Age group/years	No. Of children	Education	Duration in the UK	Type of abuse/CAS score
P1	30-39	2	Post-graduate	10 years	Severe combined=1, emotional=6
P2	40-49	6	Post-graduate	5 years	Emotional=7
P3	20-29	0	Bachelor	1 year	Physical=4, Emotional=4
P4	30-39	5	High school	1& half year	Emotional=10, physical=2
P5	20-29	1	Post-graduate	3 years	Emotional=5, physical=2
P6	20-29	1	Post-graduate	11 months	Emotional=6
P7	20-29	1	Post-graduate	3 years	Emotional=7
P8	20-29	1	Bachelor	1 year	Emotional=9
P9	30-39	2	Post-graduate	3 years	Emotional=10
P10	20-29	2	Bachelor	2 years	Emotional=5
P11	40-49	3	Bachelor	2 years	Emotional=7, harassment=3
P12	30-39	0	Post-graduate	2 years	Physical=4, harassment=2, emotional=4
P13	30-39	4	Post-graduate	4 years	Physical=5, emotional=4
P14	30-39	6	Post-graduate	2 years	Severe combined=2, harassment=4, emotional=12
P15	40-49	2	Post-graduate	5 years	Severe combined=2, emotional=10
P16	50-65	4	Bachelor	3 years	Emotional=13, severe combined=1, physical=4
P17	40-49	4	Post-graduate	2 years	Physical=8, severe combined=2, emotional=21, harassment=6
P18	30-39	5	Post-graduate	4 years	Physical=5, emotional=4
P19	30-39	2	Post-graduate	2 years	Physical=4, emotional=4,
P20	40-49	7	Post-graduate	6 years	Physical=6, emotional=4

Note: CAS scoring: Emotional=4, Severe combined abuse=1, Physical abuse=2, Harassment=2

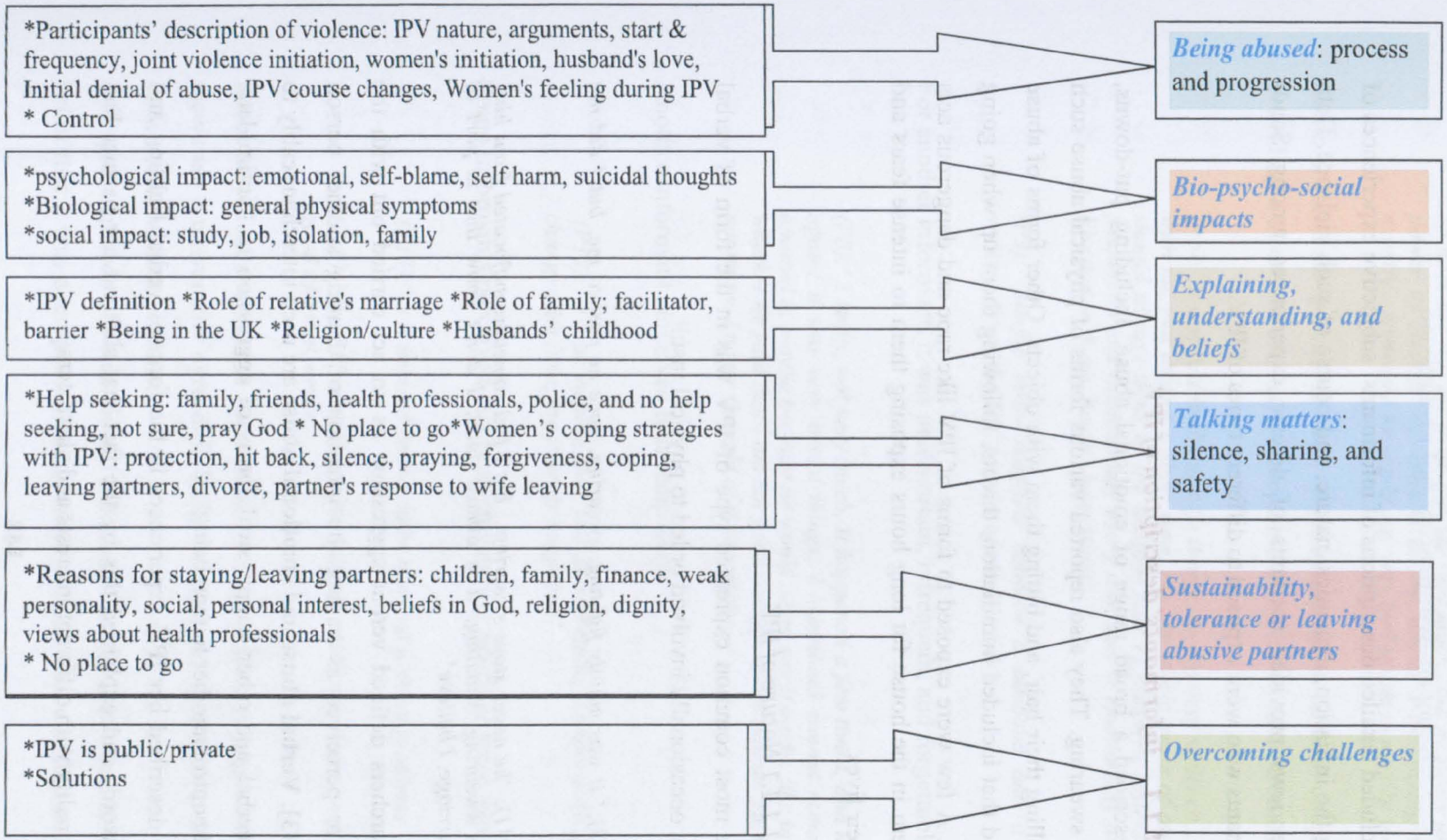

Figure 6-2: Themes emerged from the interview

6.3.1 Descriptive account

This theme included detailed descriptions of informants' subjective experiences of IPV exploring the initiation, dynamics, nature, and course of such violence. Data from the interviews provided accounts of diverse experiences among Saudi women informants who were exposed to different types of IPV.

6.3.1.1.1 Informants' description of IPV

Informants described a broad range of emotional abuse, including put-downs, shouting, and swearing. They also reported various forms of physical abuse such as beating, pulling their hair, and hitting them with objects. Other forms of abuse were described that included humiliation, threats, following them up when going outside home. A few were exposed to forms of IPV like rape and dangerous acts as locking them in the house for long hours exposing them to intense fears and threatening their lives.

6.3.1.1.1.1 Nature of IPV

Generally, the most common expressed type of IPV was in the form of verbal arguments that occasionally involved or led to physical insult.

> *(P3):' it was mainly fighting, swearing, once he pushed me, but I did not fall'*

> *(P11): 'he never stops swearing... but I feel sometime suffocated from him, his swearing, shouting, it is almost daily; I don't know that is part of marriage, I believe'*

Previous researchers defined verbal aggression as an act carried out with the intention of, or perceived as having the intention of, hurting another person emotionally [43]. **Verbal abuse** and **emotional abuse** are used interchangeably to describe the verbal and other nonphysical forms of aggression to "intimidate, subjugate, and control another human being" [270].

An informant described her IPV experiences in the form of verbal fighting and exchange of words and explained this by the fact that she and her partner had different personality with different interests and characters:

> *(P9):' I can tell you about simply how we always fight; we are different, and he does not like me to go outside very much...but he never uses the physical power to change my opinion in any matter I am saying what happened exactly....sometime he would say very bad words to me like you are stupid'*

Some informants perceived their experiences as a normal couples' violence, providing a threshold of what is acceptable and what should be considered:

> *(P6):' it was just husband-wife things, no physical violence...what happened with me was during a short time, not the whole years of our marriage, we should always think of the positive side of partners, unless he is doing it frequently and intentionally every day, this is emotionally dragging, if it is like that with me, I won't keep silent'*

> *(P3): 'simple daily conflicts between a husband and a wife, nothing serious...from the first months of our marriage'*

For another informant, it was unimportant, infrequent, and forgettable acts:

> *(P8):' I know, not very much, it happened a few times, and never happened again; it was very trivial things; I sometimes cannot remember it; I just ignored it, maybe because he would never say it again, like in your question; whether he said that I am not good enough, or he blamed me sometimes, I do not know, I never thought of it as serious'*

Another informant perceived it as temporary:

> *(P12):' I was hoping that this is something temporarily and things will change with time, but it never happened'*

Some informants perceived that problems during marriage were expected:

> *(P13):' it is impossible that to be married without problems'*

> *(P19):' but life never is empty without problems, never empty and nice and good like that, never'*

Some informants tended to use normative descriptions to present what is in their views are a universally agreed-on script of the marriage life: *"it is impossible to be married without problems."*

Infrequent episode of these violent behaviours might lead some informants to the belief that it was a temporary issue, which would resolve with time. Furthermore,

these violent episodes could be explained as '**situational couple violence**', which involved arguments that escalate to verbal aggression and ultimately might lead to physical aggression [271-272]. Usually, it does not involve a general pattern of coercive control. This common couple violence (another synonymous for situational couple violence) was described by Johnson:

> *dynamic is one in which conflict occasionally gets "out of hands", leading usually to "minor" forms of violence, and more rarely escalating into serious, sometimes even life-threatening, forms of violence (p.285).[38]*

A few informants suggested that the conflicts between the partners were due to the tension of each of them leading to impose their personality on the other. This has been called '**mutual violent control**' that involves two partners fighting for control of each other [273]. However, what Johnson describes, as situational couple violence might be applicable to women in the US, but not to Saudi women in this context. This is because situational couple violence is influenced by the societal, cultural, and religious norms that rule the lives of Saudi communities, which might be different to the ones practiced by the couples in the US. In Saudi Arabia, the concept of common couple violence might not be clear and less likely to fit in explaining experiences of some Saudi women in their intimate relationships due to the greater imbalance of gender power. Furthermore, the concept of common violence between partners in general is difficult to define and the level of acceptance of such violence differs between individuals themselves, communities and cultures (personal view).

Although the majority of abuse were verbal, for some informants, it was in the form of suspicious behaviours from the partners following women's daily activities with doubts:

> *(P12): 'he was always following my movements, my actions, when talking over the phone, my daily time-table... he would call many times asking what are you doing, to whom you are talking, and if I did not answer his call, he will be mad and shout at me saying why you did not pick up the phone, what else other than your husband you should respond to... he interfered in my dress, my activity, my friends, my work, my eating, there was a criticism on everything, if things moved from the table, anything, he would say why it has moved one centimetre'*

Another informant explained that her partner blamed her for being unable to commune with him, disobeying him, and used religion to control her:

> *(P2):' He would say that I was unable to communicate with him or that I was absent minded; that I was the one to blame and that I should avoid being blamed. Then he would talk about what I should do from a religious point of view, like I should obey my husband and not anger him. I tried being cross with him for some time and also staying away from him. In spite of his appreciation, sometimes I feel he is not at all appreciative'*

Although the majority of the types of IPV informants expressed were mild, it was severe in a few cases, where one expressed being raped, another one had broken ribs, and another being slapped on their face in front of other people:

> *(P14):' he raped me, and after that night I went out of the house and lived in a hotel, I called my brother to come and help me, he stayed with me in the hotel'*

> *(P16):' I remember once he slapped me on my face in front of his mother, because I took some money from the drawer in our room and went for shopping with his mother without him informed, then he did that, my face was marked with his fingers, sometime he would be angry at no reason; he would not talk to me sometime for a month, he ignored me'*

> *(P17):' he went crazy, kick me from everywhere in my body, he was carrying me from my hair, can you imagine my hair carrying my weight, I can see the death that day, then after he finished breaking my ribs, my hands, he started another scenario; he started to cry and said this is the evil eye, I never wanted to hurt you'*

These painful direct violence episodes were very strong and sometimes commenced without any obvious reasons to informants. These occasions of physical violence were mostly infrequent, might be a single violent episode, and therefore, had no particular pattern:

> *(P3): 'once he pushed me, never repeat it again'*

> *(P13):'it was only once in our life, I am a jealous woman, and I fear he might go with other ladies...I remembered one day in our marriage anniversary, he went out to spend time with his friends, and I was angry and I closed the door and stand in front so he cannot go outside, he pushed me and told me that I am crazy'*

> *(P16): 'He is not beating me; it was only once, but he was difficult in everything, in everything...'*

Finally, some informants' experiences of IPV extended to involve their children witnessing it or even sometimes exposing them to violence by the violent partners:

> *(P2): 'He beats them sometime... He scorns them, beats them'*

> *(P13): ' I can see the fears in their eyes, they would stay in the upper stairs watching us fighting'*

> *(P20): ' he is fighting with them, sometimes used his hand or any object to hit them, he also harassed them if they dare to tell me what he did, so I cannot leave them with him, un-safe'*

This co-occurrence of IPV with abuse of children by the male partners would endanger the children's lives and safety, if left alone with their father. Therefore, IPV extended further where partners deflected their difficulties onto a third party-their children exposing them to either witnessing or exposed to violence. This is consistent with studies that showed that child physical abuse and violence against women were frequently co-occurring [274]. In previous studies, the majority of men, who frequently assaulted their wives, during a year time, also frequently abused their children [275-276]. In another a study of 400 abused women, 53% of the fathers and 28% of the mothers had physically abused their children [203].

6.3.1.1.1.2 IPV start

The women provided a range of opinions and reason for why IPV may have started. They related it to several reasons: the tension of the first years of marriage, being young, pregnant, and lack of experiences. However, for some it was normal couples' arguments and temporary.

Some informants described that the first year of marriage was difficult and full of arguments:

> *(P2): 'The first year was full of problems. Each one of us was trying to force their opinion or personality and try to be the dominant partner'*

> *(P20):' we were fighting by hands the first year of marriage, he was very jealous, even from my dad; he would not allow me to hug him and kiss him'*

Some expressed their willingness to discuss their arguments with their partners, although this was an unhelpful debate to some participants:

> *(P18): 'I always argue with him, we swear, I was a bit stronger in the start I mean I would discuss things, debate it, argue with him but eventually I found it useless.... sometimes it is the other way round he would be quiet and calm and I would be like arguing and persuading but after a long silence from him'*

> *(P1): 'was angry, we argue, I threw words, and he threw words, I started to cry, then my voice get louder'*

The informants' explanations that the initial years of marriage triggered different sort of arguments between partners, dominated the women's perceptions of how the violence started. The informants' expression of arguments during the initial years of marriage was consistent with previous longitudinal follow up studies, which showed that emergent distress with negativity during conflicts between married couples existed in the initial stage of marriage rather than developing over time [277-278].

Other informants thought that some of the conflict episodes were mutually mediated, but expressed that some men would dominate and control the situations leading to women surrendering their opinions and accepting their partners ruling the life. Some informants blamed themselves as they were triggering the violence and thought that being tolerant and quiet might be helpful if the husband was angry and outcry:

> *(P18):' each one wants to impose his idea and insisted to take it in, like that; he wants to control everything, he wants to be in the control and I lastly sacrificed my ideas and let things go as he wished, as live goes on, like any country; it is only one ruler, and he was the ruler; I cannot do anything, it is like doing something and I am not happy or satisfied... sometime the women could be the trigger for this violence; her husband could be shouting and angry; she should not respond in the same way; she should calm him down and be patient'*

During the interviews, informants expressed that IPV episodes started by some of them, their partners, or both of them. An informant described her experience suggesting the joint initiation of IPV:

> *(P1): 'it was from both of us, sometimes I started and I did not keep quiet, then he got irritated and back to me'*

Another informant interpreted that she might have provoked her husband when he heard him speaking to another woman:

> *(P4): 'he was talking to another womn by phone....I discovered that by myself....the situation was clear and obvious, so I confronted him, and he denied that, but I insisted that I am sure, then he slapped me on my face, then I slapped him...we started that'*

Some informants disclosed that they might start the violence behaviour:

> *(P5): 'I tried to trigger him somehow; I shouted and told him I will tell my family about his behaviours'*

> *(P20): ' I was shouting and I always start hitting him, swear to him, then he would shut me up by putting his hands to seal my mouth, and would hold my hands tightly to protect himself from me, like that, but he would never start it, never, just to stop me'*

Some informants described their exposure to violence in situations where they were having some roles in the initiation, aggravating, and sometimes deliberately provoking their partners in an effort to attract the attention of their partners. However, these women might be minimising their partners' behaviour and excusing them in order to avoid escalation of their abuse or it could be an extension of the degree of control, male partners exerted on these women.

IPV episode started by partners jointly, the informant herself or the partner. Previous studies demonstrated that women perpetrated acts of IPV at rates that were comparable to men [63, 279]. However, it has been suggested that women's violence needs to be understood differently because it is occurring within a social culture that both create and maintain differential power relations between men and women [272]. Here, some informants were explicitly defining their role in the

start or exacerbations of the violent episodes that might reflect their level of awareness of the circumstances surrounding the acts. Some informants might also feel they had to curb their behaviours to stop escalation of arguments.

The conflicts and tensions could extend into major life transitions and stressful events, e.g. pregnancy. An informant stated that arguments and tension occurred more during pregnancy:

> *(P2): 'Arguments and tension happened during each pregnancy, but also during other times because I was working, and stayed long hours away from the house. His business was on and off and this too affected his personality; a different location, different environment and different circumstances affected his business and it took him time to adapt'*

Pregnancy could be also a contextual factor adding to the stress a woman could be exposed to during early years of marriage, leading to a dramatic change in pattern of intimacy and communication, and decline in sexual quality [280].
Several informants expressed also that being married to complete strangers, as dictated by the culture that prevented any kind of relationship prior to marriage, was a difficult period for the women, and that it took them months, and for some years, to know each other. Some informants assumed this, as a possible triggering factor to their arguments in the first year of marriage.

> *(P9): ' the first years were difficult than the rest...you know a person you never know suddenly you live with him, even friends when it comes to know them, it takes time to know them in the start, but after that you get used to them, I expect my first years in marriage were really difficult'*

> *(P12): ' from my point of view, a person you never know, you would try to understand him and tried to meet his requirements, what he likes, marriage needs some scarification in life, I mean also patience'*

> *(P15): 'you know in our culture people would say at the beginning it is not easy to get along with your husband, not easy to adapt to him, I thought this should be the beginning, I was saying to myself'*

> *(P18): ' no one can understand the other problems; everyone is different than the other one, you have to know him first, it depends sometime on the woman' mentality trying to understand her husband and try to understand where she is situated, and I believe not less than three years until the woman can get used to him, maybe enough, may be take longer'*

Some informants described their adaptation process to live with their partners by allowing the new relationship to develop peacefully without arguments in an effort from them to understand themselves and their partners.

However, some informants expressed the positive role of some of the cultural norms among Saudi society such as to marry your cousins compared to the UK society. This was a protecting factor for the women against being abused by their related partners. Couples who were relatives would have a long time to know each other before being married and became familiar with everyone likes, and dislikes:

> *(P6):'I knew him for long, I don't know, because we are cousins, our personalities are close....he would consider the family bonds before doing anything bad to me or acting in any way'*

> *(P7):' he is very close to me, because he is my cousin and a lot of things we shared, many walls between us were broken because of this; I always feel at ease to discuss things, I do not know some people may believe the opposite but not me; he knows a lot about me because we brought up almost together'*

Similar findings were reported in a study conducted among Egyptian women, showed that wives of paternal cousins had lower odds of physical violence [281]. Thus, such marriages appeared to confer protection to some women, perhaps because the husband's background is better known and the woman's kin is more vested to intervene in disputes, or the husband could be less likely to do anything due to being related to their in-laws. Moreover, these women might feel less isolated and not feel the same need than the other women expressed when needing to exert their efforts in the early years of the relationship when it was with a stranger.

Some informants expressed other factors that might have a role in IPV initiation such as younger age and lack of experiences. A few young informants blamed their lack of experience for the occurrence of IPV:

> *(P4):' I do not know....maybe I was young and silly to some extent like other girls in my age....I was blind I know little about life....this made me less experienced and did not know how to behave with others'*

> *(P14): 'I know it took me ages to understand, because I was married young and not very experienced'*

These young inexperienced informants might also be worse by their lack of knowledge about their rights to be respected and cared for by their partners. Islam dictated men to be respectful and merciful to women.

After describing the nature and start of their IPV experiences, many informants explained such experience as an issue of "***control***" which I described in the following section.

6.3.1.1.2 Control

Control was a key issue that was brought up by my informants when exploring their experiences of IPV. The narrative style shifted here when informants described their lives in which a sense of autonomy was lacking and considered it the main key issue in the whole experience of IPV controlling every aspect of a woman's life:

> *(P10):' he does not want me to continue my postgraduate study or even to work'*
>
> *(P12):' controlling me very much, in the way I dress, selecting what I have to dress, control on the way you decide your day... also part of his control, he refused me to go for social gathering with my relatives and friends, without giving any reasons, no logic, controlling everything... you the dangerous part of his control, when he leaves the house, he will lock the door, the windows, and I would have no access to what so ever'*
>
> *(P13):' he does not want me to go outside;, he prevented me many times, and I have to obey him'*
>
> *(P14):' I was blind, I was under his spell; controlling me, following every movements of my life'*
>
> *(P15):' even socially I am not allowed to go out when he is travelling outside country; he prevented me, can you imagine'*

Control by the male partners manifested in many aspects of informant' life, spanning from her choice to learn and commence any sort of education, to her social life to the extent of implying risk to her safety.

Some informants perceived their partners as barriers to their career and self-development:

> *(P14):' he was trying not to make me successful in my career; he always tried to prevent me from going outside and talk to men'*

> *(P15):' in Saudi he is different;, he would not allow me to talk to men, never happy to go for work, I cannot understand it until now; he wanted me to be liberal and free to drink alcohol here in the UK, but not to go for work, it is just a double standard'*

Talking to men other than a husband and some male relatives in Saudi is a major issue that is rejected by male partners and might create conflicts between partners. However, ***control*** sometime used as a life-saving mechanism when one of my informants tried to kill herself, the husband violently reacted and pulled her hands to control the woman preventing her from hurting herself. This informant reported this act in the survey questionnaire but was not given the space to explain how and why it happened:

> *(P1): 'It was on another occasion, when I use the knife to kill myself, he tried to catch me, but not hitting me, jumping on me, controlling me physical, to the extent I fell down, with my head hitting the wall, and he lost his nerves, he tried to catch me, but not hitting me...only pulling or pushing me to control me, sitting above me'*

With a few informants, such ***control*** was expressed and explained in combination with the husband' love:

> *(P1): 'he loves me a lot to the degree of sickness...to the degree that he can prevent me from seeing my father, family'*

> *(P13): 'Thanks God, my husband loves me a lot, but the family rules are disturbing, his family as I told you, they want him to control me, and I do not like anybody to force his ideas on me, no I do not like it'*

This mixing of insights between the love and control by the male partners, added another perspective of how some informants might understand the issue of IPV. Such love-controlled combination, I think, seemed to be like two forces: love as the positive charging force, and the control as the negative charging one. These forces might act to balance or minimise the violent acts in the eyes of women. This has been explained by previous researchers as 'positive inducements' that male partners used to control their partners such as showing their care and love, or

use what is called resource display acts, e.g. buying expensive gifts to their female partners [282].

The main dominant feature characterising IPV described by the majority of informants was the control by the partner regardless of the type of violence. Several informants believed that their partners' intention to control them was embedded and drive the acts of violence they practiced against women emotionally, physically or socially. This control manifested by various forms as represented by the informants taking different shapes and practices of which some are classified internationally as violations of human rights (locked stranded in the house, not allowed to have job or education). However, in Saudi Arabia, these acts are practiced by men legally and not yet considered violation of human rights but as tribal norms, men should do. Therefore, Saudi Arabia government was accused of violating women's rights by the Human Rights Watch [283]. In their report 'Perpetual Minors', they highlighted that Saudi government denied the women's rights to education, travel, and medical treatment without the permission of her male guardian. Such control by male partners has been emphasised by Stets's behavioural framework that the desire to control women's behaviours is the central motivating factor for IPV. Such controlling behaviours included limiting women's contact with friends (especially male friends) [284]. Other researchers defined coercive control as attempts by men to limit women's contact with other men or with family and friends, an insistence on knowing where she is and whom she is with [285]. A study using nationally representative samples of women from nine countries demonstrated that husbands controlling behaviour was associated with a higher risk of violence against women in all countries included in the study [286]. Controlling behaviour in this study was defined as ''whether the respondent's husband is jealous or angry if she talks to other men; he frequently accuses her of being unfaithful; he does not permit her to meet her girlfriends; he limits her contacts with her family; he insists on knowing where she is all the time' (p. 68). Some of these acts were similarly expressed by my informants in the above quotes.

In summary, the informants' experiences of partner violence were mostly verbal and emotional in nature such as arguments and swearing, which were infrequent and did not follow a regular pattern. IPV episode started by partners jointly, the informant herself or the partner. The main dominant feature characterising IPV described by the majority of informants was the control by the partner regardless of the type of violence. Several informants believed that their partners' intention to control them was embedded and drive the acts of violence they practiced against women emotionally, physically or socially.

This theme of being abused: process and progression of IPV, contributed to a better understanding of IPV. Identifying the process, nature and progression of IPV would be theoretically valuable and might provide information relevant to developing interventions designed to reduce IPV or to help women on how to respond to such violence.

Having described the theme of being abused: process and progression of IPV, I will discuss the next theme of bio-psycho-social impacts of such violence on informants' health and well-being in the following section.

After expressing their IPV experiences, my informants disclosed different ways that IPV influenced their health and well-being in the form of a complex of physical multi-symptoms and signs, emotional and social impacts that compromised their general well-being. These health impacts are discussed in the following section.

Many of my informants expressed that IPV has made them stressed, lonely, with lack of concentration:

> *(P11): 'whole of me is suffering, a lot, many things are affecting me, and I cried sometimes, I feel lonely'*
>
> *(P12): 'it was a very bad feeling... I was crying continuously'*

> *(P19): 'I cannot concentrate... very stressed...I was torn between him and my career'*

Previous studies showed that women who are exposed to IPV experienced more stress than non-abused women [287-288]. The researchers of these studies showed that stress mediated the direct relationship between abuse and physical health, accounting for 80% of the indirect effect of abuse on women's physical health.

Some informants characterized themselves as depressed:

> *(P3):'I always have headaches, I lost my concentration sometimes during the classes, feeling down, and sometimes I cried without any reason'*

> *(P12):' I was very depressed... lost the interest in everything in life'*

> *(P17):' I was crying, very depressed... I cried sometimes even when in public places, I do not care'*

> *(P18):' I feel very anxious and depressed'*

Some informants articulated possible psychologically effects of IPV by expressing their sense of anxiety, low mood, and lost the interest in life.
An informant even suffered further stress and reached the stage of panic attacks:

> *(P20):' I started to have panic attacks, and received treatment for that, I always cry... I was very depressed, without any reason, now I don't consider myself happy; I don't know'*

In a previous study, women who experienced IPV are more likely to report diminished physical and mental health [14]. Other studies showed also that high level of controlling behaviours from the male partner had greater negative physical and psychological effects for abused women, including fear, injury, and depressive and post-traumatic stress disorder symptoms [289-290].
Another physically and emotionally abused informant disclosed her suicidal thoughts:

> *(P1):' I repeated to him twenty times that I do not want to live with you, but it is better to die....I reached this stage...I thought of killing myself...but I did not....it was the worst thing'*

She even tried to harm herself:

> *(P1): 'He never used physical force...It was only on one occasion, when I use the knife to kill myself... I was frightened, from everything, afraid that I will fly from his hands, he jumped on me, it was terrible, but he did not mean to hit me, he wanted to protect me from killing myself'*

This in accordance with what other researchers noted that among the more serious emotional effects for abuse victims was the consequence of engaging in suicidal ideation and actions [291-292].

IPV might permanently mark the woman's life with long-term consequences leaving them suppressed with a loss of confidence as one of my informants expressed:

> *(P15):' it affects my confidence, a lot; I still suffer from lower confidence, until now, because he suppressed me for long'*

During or after the IPV, some informants expressed their feelings of fears, hatred, uncertainty, and degradation:

> *(P12):' I was afraid; it was very bad feelings'*
>
> *(P13):' I felt humiliated; I felt I am nothing'*
>
> *(P17):' I never felt safe with him and even in my family house'*

My informants conveyed several emotional feelings of low mood, crying, fears, and degradation. Similar feelings were expressed in a previous study describing that women exposed to IPV had feelings of being depressed, angry, fearful, embarrassed, confused, ashamed, hopeless, and humiliated or developing low self-esteem, self-blame, and uncertainty [293].

Some abused informants described feelings of loss of feelings of self-pride, and insecurity, leaving them with sense of fears and unsafe:

> *(P12): 'it was damaging, destroying; I lost the trust and safety in marriage, I lost my-self pride, this is abuse; I was not able to help or give something to anyone'*

(P17):' I was keeping my scream inside me, I did not want my children to hear it; he was following me that night, like a killer watching his victim'

(P18):' It was a very bad feeling, very bad, always I felt depressed and regret marrying him; I would think of divorce, you know women, it was periods of flying and instability then I would reconsider it and keep quiet and would say to myself; that is life always full of problems'

(P20):' I still feel afraid because I cannot predict his behaviours'

(P7):' I am afraid he may think of having another wife'

The fears of the last woman might result from a common Saudi practice, which originated from a cultural and religious background that allowed men to have more than one wife. Hence, men might deliberately use this privilege to emotionally abuse and control their female partners.

An informant who has a physical disability and had an argument with her partner one day, described her strong feelings when he reminded her, of how he surrendered his life by agreeing to live with a handicapped woman like her:

(P18): 'I felt bad...he would throw some strong words like a bullet thing, like one day he said; I did sacrificed by marring you with this;, he means my paralysed leg, it was like a mountain thrown over me, it was really hard; I cannot describe it, I cannot, then I would keep silent; I felt very anxious and depressed'

This woman felt that her disability was a weak point that limited even her ability to respond to the humiliation from her partner and rendered her to be silent.

6.3.1.3.1 Physical impact

My informants described how IPV affected their physical health. For instance, some felt general body fatigue and headache:

(P1):' I have no energy; I feel tired'

(P11):' it caused me headache, nauseating, disgusting'

Some informants reported losing their appetite:

(P5):' I lost my appetite'

(P6): 'I lost my appetite to food sometime'

(P12):' I lost the appetite... I then started to develop migraine'

An informant who was diagnosed with irritable bowel syndrome also described how she recovered from her symptoms after leaving her abuser partner:

(P15):' I developed irritable bowel syndrome, now I do not have it after I left him'

Some informants talked how the abuse would affect their skin developing some sort of sensitivity and related it to their lower immune system:

(P1):' I developed sensitivity in my skin...I believe it is my immune system could be disturbed when sudden things like violence happened'

(P14):' I had many times skin rashes and itching, I believe my immunity was low at that time; I was not eating well; I had headache, I was very weak fatigued, cannot do simple things in the house'

This was consistent with a previous study, which showed that abused women were more likely to be diagnosed with different health conditions such as migraine, headache, chronic pain, and chronic fatigue [18]. This has been explained by stress that accounted for the indirect effect of abuse on women's physical health problems.

With a few informants, their physical long-standing conditions made them vulnerable to emotional IPV from their partners, for example one informant who was obviously obese said:

(P11): 'he always criticises my weight, and the way I look, and this really upset me and feel bad about myself being fat; he looks to other women and compared me with them'

Another physically disabled informant expressed her feelings when her partner reminded her that he compromised his life by accepting her as a wife with such disability:

> *(P18):' I felt very bad whenever he reminded me of my paralysed leg; I felt very anxious and depressed'*

These two informants had health conditions (physical disability, obesity) that were not directly resulting from IPV. However, they described how stress from abuse negatively affected their emotional well-being. Previous studies have shown that women with disabilities are at risk, more commonly, from intimate partner's violence than women without disabilities [294]. This is because they may not be able to call for help. Women with disabilities face also the risk of increased social isolation and lower self-esteem, which may increase their emotional and economic dependency on their violent partners [295-296]. Economic and emotional dependency could impede a woman's ability to terminate an abusive relationship. This might explain my informant's silence when verbally abused by her partner. Another qualitative study, with women who had pre-existing chronic medical conditions and described their IPV experiences, discussed the complex intersection between IPV and health [297]. Findings from this study revealed that: 1) IPV leading to adverse health effects, 2) IPV worsening already compromised health, and 3) women's illness or disability increasing dependency on abusive partners, thereby lengthening the duration of IPV exposure. Women in this study describe bidirectional and cyclical ways through which IPV and health intersect over time. The researchers showed that these women echoed their feelings of stress and how the stress of the relationship affected their health.

6.3.1.3.2 Social impact

Social well-being is influenced by network of friends and relatives, and indicates how people experience their connections with others around them. With my informants, IPV also interfered with women's social well-being as some lost the interest in socializing with their friends:

> *(P5):' I lost my appetite; I did not like to go out and socialise with my friends'*

Another young professional informant described how her violent husband was following her and checking every single activity that she was doing, even during

her working hours leading her to isolate herself from facing and socializing with her colleagues:

> *(P12): 'will ask about every details from the moment I wake up, what have you done, who called you and so on, this really disturbed the flow of my work....my performance was getting less and less, not like before, even my colleagues noticed that, they were saying; you are not anymore active, even my friends, they would diagnose me as a depressed person, yah the way I look, you walk and your head down to the floor, walking slowly and did not want to talk to anyone'*

This informant expressed how IPV affected her work communications and performance, and how this was obvious even to her colleagues at the workplace. This is consistent with what previous informants expressed about their partners who prevented them socialising with men and subsequently would affect their career as professionals. This social impact of IPV has been explained by previous researchers who argued that violence endures in large part because the social structure of interpersonal relationships within societies continues to provide the fertile conditions that spawn and perpetuate the use of violence. Dobash and Dobash suggested that violent men often isolate their victims from family and friends and prevent them from working outside the home, going to school, or associating with anyone outside the immediate family [298]. Men's behaviour in restricting women from working outside the home is a way of "restoring power" within the household by the husband. Similarly, Saudi women are confined to their home and have to take permission from their partners even if they are going to work or want to continue their education.

In summary, informants expressed many impacts of IPV on their physical, psychological, and social well-being. A few of my informants were specifically exposed to IPV because of their chronic medical conditions. Understanding the bio-psycho-social impacts of IPV would help in setting up help resources to the abused women and would aid health professionals to anticipate these impacts when encountering these women with possibly medically unexplained symptoms and signs of IPV in daily practice.

After discussing the theme of the bio-psycho-social impacts of IPV, I will discuss the next theme exploring my informants' understanding and beliefs regarding IPV in the following section.

This theme described my informants' beliefs and intellectual understanding regarding the role of religion, culture, partner's childhood, and other issues raised by them regarding IPV. It provided informants' understanding about the definition of IPV, role of the family in IPV occurrence. My informants also explained the advantages and disadvantages of being in the UK and how they were related to IPV.

6.3.1.4.1 IPV definition

The beliefs of the informants extended to conceptualise and define IPV differently and classify their experiences according to their understanding and perceptions of the acts that constituted violence in their intimate partnerships. Informants' subjective definition of IPV includes any physical, verbal, sexual, or a combination of such act or any act they think or believe it as partner violence.

Some informants defined controlling them or forcing them to act in certain ways different from what they wanted to do, as an abuse:

> *(P1): 'anything that controls me or tries to impose anything on me is abuse...this is more than physical abuse, because this will lead to a cycle of problems'*

> *(P15) 'for me, it is the control of personal choice, control of freedom, your education, you cannot talk, cannot go out, you are prisoner in a single cell; you know how, this is the peak of punishment; this affected you forever, if you burn your hand, it will heal but this scar will never heal'*

> *(P17): 'I believe it is imposing ideas and principles on women is an abuse, forcing her to do things without believing is violence, violent to her freedom to think, to decide for herself her life, yah like that, but the physical violence is very obvious, predictable, you can see it, but the suppression is hidden, you cannot see it by your eyes, control in every aspect of the women's life, instructions as if she has no brain to think, and the only thing you can do to reject it is to ask for divorce, or accept violence'*

For these women, restrictions on their freedom to study, socialise, and commence any daily life activities, were considered part of IPV. Some informants expressed that these controlling behaviours were even more influential than burning their hands. Coercive control was a scar that will never heal, and some informants described their situation as prisoners. Some informants told that inflicting ideas or behaviours on them was violence to their freedom in deciding how to live.

Others would define IPV as the verbal shouting and 'bad tongues'. This verbal abuse considered by several informants a worse type of IPV than the physical one as it was expressed as more psychologically damaging for some:

> *(P4): 'I think any type of physical, sexual and emotional...all are abused....it is not a normal way of life...anything that happened by force is considered abuse....maybe I was not beaten very hard....but the 24 hours humiliation and emotional stress from his behaviours are really abuse by itself'*

> *(P13):'it depends, violence has many shapes, but some strong words are painful than the physical pain if he hits you, I do not know, it under-evaluates women, degrades them'*

> *(P19):' It depends, there are different types, the worst thing is the swearing, the bad tongue; it does affect me psychologically, I can see that physical force and hitting are bad but I feel the control and ruling of a man on his wife; I feel inside that I am like a weak creature that need to be controlled and eradicated'*

My informants emphasized the continuity and intensity of verbal abuse as the key issues in defining abuse. They seemed aware of the recognized types of IPV such as the physical and emotional violence, but they were very specific when mentioned that the verbal abuse and control imposed by their partners were the most frequent and insulting to them.

A few informants mentioned that degradation, under-estimation and social alienations practiced by their partners were seen as even more insulting than physical abuse:

> *(P2): 'Scorning is the simplest thing, therefore, anything more than that is abuse. Beating of course, but I did not suffer this kind. Other examples of abuse are social alienation and under estimation, practiced by many husbands'*

> *(P14):' if I did a small mistake, he would not say anything, but would ignore me for days, may be weeks, degrading me, and this might not be considered abuse maybe with you, but for me it is killing, this is abuse, ignorance, cannot discuss anything, I did not know what to do'*

> *(P16): 'everybody would say the physical beating, but no, it is the insult that hurts, I mean swearing, shouting, degrade you in front of other people, this is all abuse, even if he said; you are stupid, you don't understand, this is more hurting'*

Another informant considered the emotional violence as a type of IPV, but if it was frequent and on a daily basis. However, she would accept some occasional emotional violence acts if it happened because of anger from both couples:

> *(P8): 'the emotional abuse....yah; if it is like every day, I would not tolerate it as well, but if it happens occasionally, this is very acceptable...we are human...cannot hide our anger if we do not like some acts from others, and husbands are similar....specifically my husband, he would never repeat it if I did not like it, and he would apologize at the end, and this what made us women forget it easily'*

She highlighted that apologies from a partner and a promise of not repeating the abusive act would be enough for a woman to forgive him.

Another emotionally abused informant rejected that what she experienced was not an abuse and hoped that it is a transitory issue:

> *(P18):' No, this is not abuse [emotional abuse]; it is not physical beating, even if emotionally upset, it depends on your psychology, I don't consider it; this is what is happening with me, because this is temporary things and will end at some point'*

Her explanation of her situation might reflect her coping mechanism or even denial, or she might consider only abuse to be physical rather than emotional.

Control extended to be a key issue in my participants' definition of IPV. Additionally, the continuity and intensity of IPV acts were of paramount importance in defining IPV. Several participants addressed that emotional abuse was more insulting and painful than physical abuse such as burning their hands. Some participants accepted emotional abuse if it was infrequent and accompanied by apologies from the partner. This might explain the findings from a recent study which showed that women exposed to emotional IPV alone have a high

probability of continued exposure to the same type of IPV with a low possibility of recovery as they continued to have higher levels of depressive and post-traumatic stress disorder (PTSD) symptomatology than non-abused women [299]. Emotionally abused informants seemed to be accepting such violence, and this might lead to their continuous exposure to emotional abuse.

Definition of IPV addressed by my informants involved not only the acts, but the effect of such acts on the women. This link between the behaviours and impacts of such acts on women was not possible to explore using the CAS questionnaire alone because it contains no items that ask about the impacts of IPV. Additionally, it might reflect their socio-cultural or political contexts where they were living before coming to the UK. Yoshihama argued that there are major limitations to mainstream measures of domestic violence because they lack socio-cultural context such as gender roles and social norms in partners' relationships [300]. Some of my informants believed that these culturally specific forms of abuse (denying them the rights for education and travel by the Saudi civil law) as being considerably more severe than acts such as slapping, and beating. These socio-political forces imposed by the Saudi culture and approved by the civil law, are explained by Mann and Grimes to be structures of oppression that are somehow larger than the individuals who produced them and are integral to understanding IPV in diverse communities [301].

Some informants' beliefs regarding the act of having sex with the wife without her consent were discussed. They believed that such acts considered abuse, although in Islam, women are advised not to refuse the husband's request to have sex. However, my informants expressed that some men interpreted Islam according to their needs:

> *(P3): 'of course abuse...She is a human being'*
>
> *(P4):' yah, it is abuse...she is human and have the right to say no'*
>
> *(P14): 'No, at all, men used and interpreted Islam sayings according to their needs; Islam is clean from their dirty thoughts and needs; Islam is merciful, but that what they think'*

However, a few informants held a conservative view believed that women should fulfil husband's desire to have sex, even if they did not want to have it themselves:

> *(P2): 'because I feared, as I understood, there would be cursing. That was what encouraged me not to refuse even if I did not desire to have sex... because I fear cursing and I fear the result of making the husband angry'*

> *(P8): ' No, it is not, God asked us to obey the man wants, because it is a sin if we refused, and I think it is something we have to follow'*

A few informants who held strong religious beliefs did not see some violent acts as IPV, for example, forcing her to have sex, but rather a religious obligation to be fulfilled. Sex that is unwanted by a woman and occurs without her consent is defined as coerced sex or rape [302]. A few of my informants expressed similar beliefs to many women from different countries in the WHO multi-country study where 10-20% of women surveyed in 5 out of 10 countries believed that a woman does not have a right to refuse sex to her husband under any circumstances [303]. Some of my informants even believed that it would be a sin if a woman refused to have sex with her husband.

6.3.1.4.2 Role of family

The role of the family in the experiences of IPV among informants was an important factor that concerned the majority of my informants. Families might influence IPV experiences of partners, directly or indirectly. These emerged from some culturally rooted norms in Saudi society where both parents of partners sometimes had to rule the life of partners and decide even where they live and how to spend their money:

> *(P5): ' his family still interfering with our life....still they want to control him from far distance...they forced him to live in the family house when the father discovered that he is not going to the mosque'*

> *(P13); ' his family interfered at that time... in the first years of marriage his family wanted him to save money and sometime they asked him to take my salary... and I noticed when he is back from visiting his family, he will be upset... his family were not happy that I continued my education and now I got a job, they think I will not take care of him..., if my husband and I are comfortable like that why they should interfere, even my class mates have the*

> *same problem, it is not only me; we were sitting together talking about the same subject'*

Interferences from parents in law could expand to prevent some informants from continuing their education, and this created stress between the couples. However, informants were aware that similar interferences were happening in their friends' lives as they shared their stories.

Sometimes the in-laws served as an instigating factor in conflicts between couples. Occasionally, however, mothers-in-law seemed to have created further tensions, for instance, by reporting the incident to the husband (her son) who then had engaged in conflict with his wife. This was similar to one of my informants who faced same problems from her mother in law who interfered in her life and surprisingly read-through her periods cycles to check whether she is pregnant:

> *(P13):'his mother never stopped following us, like that, she is even asking me to get pregnant again; she counted my periods days, can you imagine that....his mother did not know I am studying her, because she will thought I am not taking care of her son'*

Family interference was a key issue that was explained by my informants in relation to IPV. Similarly, interference from the parents-in-law was reported also in other tribal Muslim communities. In a study among Afghan women who were interviewed to explore their IPV experiences, likewise, the parents-in-law' interference and authority, expressed during couples' conflicts, were mentioned as ideas that were reinforced by the cultural norms surrounding interactions between daughters-in-law and parents-in-law [304]. However, authors of this study emphasized that the positioning of parents-in-law seemed to both exacerbate and protect against violence. In the same way, in India, mothers-in-law act as 'proxy' men while perpetuating violence and exercising control over their daughters-in-law [305].

Informants' understanding and explanation of IPV were then expanded from the individual and family spheres to a broader horizon exploring the role of immigration and the influence of being in the UK on their intimate relationships and IPV. I will discuss these issues in the below section.

6.3.1.4.3 Being in the UK

Informants had been living in the UK for variable length of periods for different reasons, among which was mainly studying or working. Being in the UK as immigrants was one of the issues that was explored during the interview and explained my informants' understanding of IPV.

The majority of my informants felt that they were socially isolated in the UK. Related Saudi families (parents, adult sons and daughters) often live close to each other. Therefore, several informants expressed the feeling that they have lost such open and nearby housing that, they usually were living in Saudi Arabia, allowing intervention by rest of the family if any woman exposed to IPV and needed help. Hence, much of the protection offered in such a communal community has been lost when they reside in the UK. Furthermore, if both members of the couple were isolated in an unfamiliar country (UK), this could lead to its own tensions:

> *(P3): ' we lived together alone and clashes started...then I felt alone, and my husband could not understand why I am not liking the life in UK...I was embarrassed'*

> *(P5): 'Here I feel alone; in Saudi Arabia, you can speak to a friend, but here, no one to talk to'*

> *(P7): 'society here is really different; no one cares about others, you know in Saudi, everybody will care about you, you see your relatives every weekend....everybody knows about each other...yah, like that...nobody you can talk to; at least to speak up your feeling'*

One informant compared her previous life in Saudi with here in the UK. The education structure in Saudi Arabia is different to the setup of the UK education that allows for mixing between men and women. In Saudi, this is not acceptable culturally and therefore, this could create tensions and conflicts between partners:

> *(P7): 'when I am back every day from the college, he would question me, what did you do, how many males in your class....like that...you know....I was completely having a separate female life in Saudi during my University study and now suddenly mixed with men, and it is really not easy'*

Some informants thought that life in the UK is stressful and language was a problem for a few in the start:

> *(P6): 'then we moved to the UK; I felt that problems started here...it was a period of a devil...I mean we were fighting, and then he suddenly left the house'*

> *(P7):' I could not understand what the society was about, how they think, language was also difficult in [large city in the UK]....this affects me initially, and this made me easily losing my temper...especially when I come back to the house....as if I come from another space...English....English all the time'*

For another informant the freedom in the UK as she explained was a problem, as it seemed to influence her conservative husband who was attracted by the open UK culture and did not care for the family:

> *(P18):' It is worse, a lot worse; I am still looking for answers why is this happening, but may be because of the too much freedom here in the UK is different than our life as Saudi, you know, he changed here; he would go outside a lot, he started to have friends not the type of ones he used to; I mean he was conservative; but now a bit liberal, they are different than the ones in Saudi, mostly singles, and he started to act like teens'*

Another informant explained that the life in the UK is difficult and she and her partner had to compromise allowing her to continue her education:

> *(P19):' it is getting worse here in the UK; too much pressure when we arrived, life here is difficult; he has to accept a few things, and I have to accept a few as well, I mean he accepted to come with me and has no role to do and has to take care sometimes of the children while I am studying'*

Equally, several informants were happy about the living here in the UK, because they can see each other more frequently than it was in Saudi:

> *(P10):' truly he is much better here; I did not see him very frequently in Saudi, but here he is close to me, not very much commitments; I know him more and I his friends, our relationship is stronger now; we can discuss things, before you know we never talk about things'*

> *(P11):' actually I feel close to him here in the UK; in Saudi we have double commitments, women responsible about the husband and his family, my family as well; it is too much, but here it is less'*

Some informants pointed out, specifically, to the benefit of being in the UK as they can call the police anytime. They compared the police service in the UK to

that in Saudi where, if called, police officers would not be able to do anything for the abused women because there is no legislation in Saudi law regarding IPV. Several informants believed that their husbands were very much controlled and less aggressive in the UK as they might be prosecuted or charged if they were violent towards their children or to women:

> *(P9): ' here in the UK, I can tell the police because I trust that they would not mention my name to any and also you know they are capable to protect me '*

> *(P20): 'Here much better, much better; he is less aggressive, much controlled by the system here... children are well informed here on how to complain if exposed to violence and my children know about that and the father knows that as well; in Saudi he would do anything and nobody will say anything to him '*

Another benefit some informants expressed was being away from the family in law interferences in their lives. Therefore, some realised the benefits of being in the UK as independent individuals, as there would be no intrusion from the family:

> *(P6): 'I feel very independent here in the UK; no more social commitments '*

> *(P9): 'here life has two things good and bad; partners could be close together and would have good chance to know each other, I mean all the time together, you know in Saudi we are committed to social obligations; we have to visit this and that '*

> *(P13): ' life in the UK, here, no body interfere with our life; nobody even if they interfere they would just ask; how is things, are you OK, nothing more than that, no interference; they do not know what we are doing, especially, his mother she did not know I am studying her, because she will thought I am not taking care of her son '*

> *(P17): 'very much better, no interference from his mother, he is afraid from the system here in the UK, you know, much less, I see him more here, in Saudi I never spend 2 hours continuous together with him, he is much attached to his family '*

Being in the UK was advantageous to some of my informants as it relieved them from the interferences of the parents in law and allowed the couples to be close to each other compared to the expected life in Saudi Arabia. Some informants pointed to the benefit of the legislative system in the UK and how it had a role in

controlling the violent behaviours of their partners. However, it was stressful, difficult, and a disadvantage for a few as the liberty of life in the UK changed their husband for the worse, resulting in him neglecting their children and spending most of their time outside the family house. Numerous researchers have also found that immigrants are less violent at the individual level, especially if strong social ties and cultural values are present [306]. This is because social ties increase supervision and facilitate the transmission of values about acceptable behaviours [307]. However, some informants expressed some disadvantages for being in the UK as they were distant from their families. Therefore, social ties may work differently. Additionally, other factors can play a role such as length of stay in the UK, partners' education and other possible socio-demographic profiles. Furthermore, impact of the migration might play a role such as rules regarding their eligibility for work and some visa restrictions that could create more stress to both partners.

6.3.1.4.4 Husband's childhood

The husband's childhood was mentioned spontaneously by some informants as part of their beliefs that might explain why some men were aggressive to their wives. This includes either that the partner was abused by his parents or had observed his mother abused by the father. A few informants expressed that their partners act similarly to their original parents:

> *(P8):' husbands sometime behave in the same way as his father doing with his mother; my husband told me; that he never heard his father saying bad words to his mother...I think that is why, he rarely does it with me, he is nice'*

> *(P14):' I recognized that he was suppressed as a child by his father, his father was very controlling, but his mother was very weak, and she was under his father control, so I guess my husband is repeating the same thing; he is trying to be like his father, and I represented his mother, and that is how life it should be, of course as he thinks'*

> *(P16):' he slapped me; he likes to do so in front of his family; I am not sure why, but I think because his mother was aggressive to him when he was child, she was suppressing him... his mother was difficult; she was very tough with him'*

> *(P17): 'even the man he gets used to see his father like that so he is applying what he saw when he was a child; the same role'*

These women believed that partner' behaviour is largely influenced by the way they were raised during their childhood, for example: if they were suppressed, or even abused by their parents, they would apply the same acts when grown as adults. My informants' expressions were similar to findings from a previous study that showed that exposure to violence in the family of origin might lead to subsequent IPV in adulthood [308]. Although, this has been a contested subject in the literature, not all children who are exposed to violence from their families would be violent when they became adults. Akers and colleagues highlighted the positive and negative enforcement in the learning process of IPV [309]. Children exposed to family violence might learn the rationale of violence and hence positively enforce such behaviours (being violent) in adult life with their partners. Similarly, in this research, some informants expressed their beliefs in the influence of partners 'childhood on their behaviours as adults. One study showed that men who were neglected, as children, were more likely to engage in physical abuse of a spouse later in life and those who witnessed parental violence were significantly more likely to engage in psychological abuse of a spouse [310].

6.3.1.4.5 Religion and culture

Religion, culture or both were among the topic guide issues explored during the interviews, for example: participants were asked whether religion or culture had a role in influencing IPV occurrence. In the religion of Islam, men are responsible exclusively for all aspects of women's life, including their safety, housing, and financial obligations women could need [248]. In the holy book (the Qur'an), men are said to be:

> *'Men are the maintainers of the affairs of women, for God has preferred in bounty one of them over the other and for what they spend to sustain them from their own wealth' (Qur'an 4:34).*

Several informants recognized this responsibility, but also expressed their partners' miss-use of such instructions to control women:

> *(P1):' the guardianship that Islam gives men the duties and responsibilities to take care of women in every aspect of their life...because we are under their responsibility; they feel they have the power and capabilities to act....he always used the Islam as an excuse to control me, to correct my behaviours'*

An informant thought that it is culture, rather than the religion, which might impose the notion that men are the most important partner:

> *(P2): 'I think it's a question of culture. Men got used to believe as a male, he is the most important partner in the marriage'*

Informants seemed to be insightful of the rules of intimate relationships in Islam and of its extent.

Some informants expressed various attitudes and demonstrated age's differences in understanding the role of culture and religion in IPV. Some younger informants (27-34 years old) seemed to express their own beliefs over religion. These women explained that religion could not be enough to decide about leaving or staying with their abusive partners, and that their thoughts and feelings are of paramount importance and should be considered in the decision-making process:

> *(P1):' No I think of my values than what Islam dictated me to do'*

> *(P5): 'I knew that religion has a role in marriage life....but if I did not want to stay with him, I can do that any time, not religion; no religious reason can justify leaving or staying with him'*

> *(P7): 'there are limits for obeying husband, I have to consider myself...my feelings...I have my own opinion'*

> *(P17): 'we have been told by culture, I mean that God will not forgive you if you do not obey the husband? How come, where is our right?'*

> *(P19): 'I feel inside that I am like a weak creature that needs to be controlled and eradicated, this not what our religion said to the man, it is not his right to control her; I feel this... they manipulate religion to fit their desires and mind set'*

Some relatively older informants (43-48 years old) believed, it is a religious requirement to fulfil the needs and wants of partners. Their strong religious beliefs made them agree to have sex with their partners even they did not want to do so

because they thought that they also shall give an account in the Day of Judgment if their partners were not happy:

> *(P2): 'the religion, definite, Yes, because I feared, as I understood, there would be cursing. That was what encouraged me not to refuse even if I did not desire to have sex...Yes, because I fear cursing, and I fear the result of making the husband angry'*

> *(P18): ' It is my religion, because I will die one day, and will be with God, I don't believe in cultures, although some are in accordance with my religion then I will take them, but 90 % of my life is controlled by religion instruction, it is the way to live'*

One informant believed that men are better than women are. This suggested that she enforced the discriminative gender-based assumption believing that God shaped men superior to women physically and intellectually:

> *(P18): ' God created man better than the woman, mentally and physically, and the man should rule the house and run the life of his house; woman should be tolerant... I believe in religion, and it is my religion who makes me tolerant; I am a religious woman, and I feel happy about that, I feel comfort, I think religion is controlling the relationship making it smooth; it is not traditions or social values'*

This woman seemed to be unexpected case with different views from that of the majority of the informants. She held strong religious views about the role of men and women in the society, and expressed her comfort and happiness with this belief. This contradicted the majority of my informants' views who believed that culture had a role in IPV rather than religion.

Additionally, a few informants believed that IPV is justified if the women were not educated or cannot communicate with their partners properly:

> *(P18): ' I see that if the man is mentally stable; I believe the source could be from the woman; she could be very argumental, talkative, and should be educated how to deal delicately with her husband, specifically the current generation they do not know how to tolerate the man's life; our mothers live like that'*

> *(P9): 'problem could be from women, especially when the wife is not studying or doing any job; she would be very sensitive and thinks of anything not very important; she would be easily upset and try to search her husband's mistakes, you know when you have nothing to do'*

Some social customs enforced the notion that the man should control the woman, for example, the influence of the learnt social norms that the husband observed his father doing the same thing (violence) to his mother and this subsequently could explain his developed behaviour as an adult.

Some informants emphasised that social norms are detrimental and encouraged gender-based discrimination from childhood facilitating IPV:

> *(P3); 'social habits are more influential in facilitating women abuse....our culture gave the understanding to men that they are the strongest, do not allow women to control you....men should control....children seeing their father abusing their mother will grow like that and will see it as a normal thing and get used to it'*

> *(P12): ' it is the culture, how we brought up; if children watch their father abusing their mother; they would think this is the norm, and life will continue like that, and the victims will be us the women'*

Socially learnt values also instructed some informants, from childhood, to respect men and obey their orders:

> *(P13):' we learnt that from our family, we grown like that, husbands are very valued person and he should be respected, my mother told me so since I was child, she would ask me to bring water for my eldest brother because he is a male, and more for the husbands'*

Some informants believed that it could be a combination of culture and social values that shaped the individual beliefs and brought the children up with learnt violent attitudes later in adulthood.

> *(P14):' do not blame Islam; it is our society, our culture that created these things; the prophet Mohammad said to men; that they should treat women like a piece of delicate glass, to be gentle, not to harm them, and taking care of them every day'*

> *(P17):' it is culture, of course, not religion; if they follow religion, they would not treat us like that, and it was the norms that control us; our life is like the psychic double personality; nice, liberal outside, inside his house, restricted, with rules and we women have to accept it; we have been told by culture, I mean that God will not forgive you if you do not obey the husband? How come, where is our right?*

An informant discussed the role of culture that gives the freedom to men behaving as they like while women were accountable and required them to accept their violent partners rather than divorced and be stigmatised by their society:

> *(P20): it is culture; culture shaped us like that in every aspect of life, my religion would not say to me; ok if your husband is alcoholic, but my society and my culture would say; you have to tolerate him, be patient, like that, if the religion is the one that ruling you, it would be easy for women to leave their abuser, but the rules of culture would find excuses for them and would say; no you cannot leave the husband; everybody will point to you, everybody will talk about us as a family with a divorce daughter, women will be controlled by the cultural and society norms; cannot get her children to live with her, she is observed and accountable about every act, movements and words she is saying because she is a divorced woman'*

Some informants thought that it is the control men imposed on women, which was the most influential type of IPV, and that men might manipulate religion instruction (e.g. men should take care of women) to justify their violent behaviour. Hence, instead of taking care of women, men might control them restricting their lives in many aspects:

> *(P19):' this not what our religion said to the man, it is not his right to control her; I feel this is the worst type of abuse; they manipulate religion to fit their desires and mind set'*

There seemed a consistent thought that it was the culture rather than Islam as a religion that imposed and dictated discriminative attitudes of men towards women. This mediated attitude of control and dominance by some male partners towards women. My informants believed that culture and Saudi traditions dictated and enforced IPV rather than religion, which some men used to control women. There were age differences with regard to the role of religion in IPV, where young informants expressed their own beliefs over religion, while older women believed that it is a religious requirement to obey their partners. Arab Muslim women believed that men have the right to physically hurt and sexually desert the rebellious woman [311]. This was also consistent with a previous qualitative interview study conducted among Arab Muslim women, which, showed that they were bound to social and cultural rules leading them to accept and tolerate IPV [312].

The majority of informants agreed that it was a miss-interpretation of Islamic regulations, which were enforced and inherited by the Saudi community, allowing men to degrade women and being violent. In addition, such norms (e.g. men superior to women) might be generated and constructed by the Saudi society using the religion as an excuse to impose unfair practices such as controlling the lives of women and abusing them. Similarly, a report by the UN commission on human rights highlighted that:

> *'Though interpretations may vary, there is no question that all the world's religions are committed to the pursuit of equality and human rights. However, certain man-made practices performed by the name of religion not only denigrate individual religions but violate internationally accepted norms of human rights, including women's rights'(p.27)[313]*

Some informants believed that Islam has a positive role in preventing IPV:

> *(P4):' I do not think religion will encourage him to abuse wife...I believe religion has a role in preventing abuse if the husband knows his religion well and read Quran on how to treat women respectfully...religion is really a good way to live our lives'*

The above informants' views about religion and culture and its role in the intimate partner relationship dynamics could have ***positive*** and ***negative*** functions in partners' life. These functions depended on their ability in enabling the pursuit of goals partners aiming to reach. For example, psychological function involves a positive and a negative role such as anxiety reduction when praying God (positive), fears from God, society stigmatization (negative), social function because of the presence of support from extended families (positive), control, or dominance by men (negative), and physical function when power and control exerted by men on women.

The role of religion and/or culture in the couple's life might differ in Saudi and the UK. However, I think Saudi population are strongly attached to their religious and cultural values and might continue practicing them when abroad (see further detail in chapter 6, section 6.3.1.4.3).

Exploring the factors underpinning IPV from my informants helped to understand the barriers and facilitators to violence occurrence. Hence, this would contribute

to plan strategies to tackle these factors and to help women overcome these challenges at the individual and societal levels.

Religion, culture or both extended to influence the participants' decision to stay or leave their abusing partners, which I will explain, in the next section.

This theme explored participants' decision-making process and the factors that played a role when they decided to stay and/or leave their abusive partners. This theme is important in order to understand participants' response to their violent partners, and this would help in setting up informed based help resources to diminish these factors in the lives of these abused women.

6.3.1.5.1 Reasons for staying or leaving violent partners

Reasons for staying or leaving the violent partners were an important aspect of the sustainability, tolerance, or leaving abusive partners' theme. This helped to explain the rational and thinking process of my informants who were exposed to IPV. Informants were asked to discuss the possible reasons for staying or leaving their partners who abused them. The question was an open-ended question allowing informants to speak up their minds. However, probing questions were asked such as to clarify why some participants think that certain reasons were influential than others such as religious instructions or culture norms and their role in the decision process.

Several informants discussed divorce as a way of leaving their partners but were aware of the negative consequences of divorce such as stigmatisation by the society.

> *(P9):' I believe culture, the society beliefs, like in divorce, if you choose to be divorced, it would be difficult, society will not accept you, if you married again the new husband will not accept your children; all are social norms that control the way we live; we create it'*

> *(P13):' It is the culture; it is Saudi values, our society never merciful; they pointed to any divorce woman, I don't know, other women in the society will not like to be their friends because as they think; this divorce woman may take her husband'*

Here, some informants insisted that it is the culture, which shapes the existing Saudi social norms and drives the women's decision in determining to stay or leave their violent partners. These driving social norms would not accept divorced women, having the implication that those women who do decide to leave their partners due to violence might be stigmatised by their divorce status.

An informant discussed wider reasons why some women would stay with their partners and specifically, she pointed out that being brought up by the Saudi paternalistic society, unawareness of one's rights, and lack of knowledge about religion were obstacles to women who could leave their partners:

> *(P15): 'I believe since we brought up in paternalistic society; we never be aware of our rights as women; it is our literacy in religion that lead us to be like that [cannot decide for ourselves], if we know our rights, we will not be like that, will not hesitate to stay as long as I did, also socially it is not acceptable; my family was supportive to me'*

Some informants were uncertain whether it is religion, culture, or other reasons that influenced their decision to stay or leave their partners, leading them to stay longer with their partners:

> *(P16): ' No, nothing, not religion, not culture, nothing like that, I sometimes say to myself; why should leave, no alternative, and sometimes I say; why should I stay and exposed myself to such humiliation, even for the last minute I am thinking what to do, I do not know, I reached a stage of my age I don't care, let's go like that'*

Several informants consistently expressed that religion has no influence on their decision to stay or leave their partners, but the society values and norms that drive their choice to avoid being stigmatised or marginalized as divorce women. However, for one informant who expressed that she was religious, and all the aspects of her life were controlled not only by her husband, but also by her beliefs of the religion that made her tolerant of her partner:

> *(P18): ' I believe in religion, and it is my religion, which makes me tolerant; I am a religious woman, and I feel happy about that, I feel comfort, I think religion is controlling the relationship making it smooth; it is not traditions or social values, I do not believe in these man-made norms; they are not holy words, not God's words so why should care about them'*

Loving their children and fears of losing them were the main reasons for staying for the majority of informants:

> *(P1): 'for the sake of their children... or may be their personalities...weak women...although they are abused but some believe they have to stand it'*
>
> *(P2): 'Because of children, of course. Children are the main reason why a woman would stay with an abusive husband'*
>
> *(P4): 'Of course, my children...I lived good life and I want my children to life the same childhood...I was trying to make them live a stable life'*
>
> *(P6):' because of their children I believe...may be family will not accept them back; society even will not accept them... because our culture will label them as divorced, and this is very negative; it would be like a wound that never heals, isolates the woman from the rest'*
>
> *(P15):' my children are my weak point; I cannot live without them, so I stayed with him, it was hard but I have to do that'*
>
> *(P16): 'for me, it is for the sake of my children, because he would not allow me to leave him with the children, I cannot live without them'*

These informants expressed their responsibility and affection to their children. They wanted to keep their families together and protect their children from potential agitations and instability caused by leaving their partners. These concerns might help service providers in understanding the needs of mothers who are victims of IPV regarding their children's well-being.

One informant expressed her emotions and that her children take precedence over her own well-being and safety, when deciding to stay and accept her violent partner, as she could lose her children if she decided to leave him:

> *(P19):' it is my motherhood emotions; I love my kids, if I have to lose my husband, I would not lose my children, I can scarify myself for the sake of my children, where they can go; I am responsible, I never care about culture; I cared about my motherhood emotions, only this'*

However, one informant was not sure and speculated why she stayed with her violent partners due to other perceptions such as fear of losing her status as a stable married woman. This might have an effect on her personally, as the society might stigmatise her for being a divorced woman:

> *(P1):' may be her reputation is more important before children, because self-reputation will affect the way, she lives so she prefers to stay and with her children than allowing the community to point to her as a divorce woman'*

This woman however, did not have children yet and was speculating that her reputation would be the one aspect that women would consider when deciding to stay or leave their partners. Similarly, other Arab Muslim women (Jordanian) expressed similar reasons for staying with their abusive partners, including; the inherited social background, financial dependency, lack of family support, sacrificing self for the sake of children, and the adverse social consequences of divorce [130].

Fear of losing their children was a key issue that influenced my informants' decision to stay/leave their abusive partners, as has been commonly found across many countries [314]. They conveyed emotions, denoting caring and committed mothers who wanted to live for their children. This was similar to other Arab Muslim women, interviewed in various studies, who indicated that they were willing to accept and tolerate any type of abuse for not losing their children, and that they were living for them [130, 248]. My informants also added the fear of stigmatisation from the society and rejection of their children by the family as barriers to leaving their partners.

Another informant when deciding to stay or leave her partner considered the positive side of her partner as a reason to stay with him and expressed her dependency on his ability to raise the children:

> *(P2): 'I might consider more positive characteristics of the husband. In my case, he is easily provoked, but I feel safe by his side, and that he is more competent than me when dealing with the children and their problems'*

A participant expressed her ability to cope with her violent partner, and that she appreciated that he never repeated such a violent act:

> *(P5):' he was not bad...I can cope with him...I tried to balance things...so I told myself why should I leave him...he never repeated it, I mean beating me'*

Another informant calculated the advantages and disadvantages between living with a violent partner with intermittent problems, and the life if she has to be back to her family where she would be held responsible for her option. This woman pointed out that whatever the problems between partners, there were times when they were happy and not exposed to IPV and therefore, she thought that it would be better for women to stay with partners than going to live with their family:

> *(P2): ' In my opinion, whatever the problems are, there are times when they are off, and it's better for her to live with intermittent problems with the husband than at her family's house where everyone would blame her for her choice and make her responsible for all the failure, especially if it was really her choice to marry that man'*

Here, some informants cognitively considered some factors that women should think of before deciding to stay or leave their partners, like the positive characteristics of their partners being kind sometime, family rejection and blame. Some informants expressed the belief that leaving a violent partner is possible if a woman is strong and determined to leave her abusive partner:

> *(P7): 'she should be strong with her job, and her self-confidence will give her the strength to leave him'*

> *(P9): ' I believe being determined, strong personality, if she has enough money, I believe she would say; why should I lose my dignity, why should I humiliate myself'*

> *(P18): ' if I am strong enough and have a stable job, why should I keep quiet; I will leave him and live my life'*

These informants believed that confidence, job stability, and income were necessary for them to leave their partners.

Other informants listed several parallel factors explaining why women stayed with their violent partners such as weak personality, unemployment, fear of losing their children, and stigmatization from the society:

> *(P3): ' either she is weak, cannot make decisions, or she cannot leave him because of considerations to the society around her...may be because of children as well...also she may be not welcomed by her family to be back to them....some families are not ready to accept women after divorce....OR she*

> *is not financially supported to be independent....she can tolerate hitting or any sort of harassment if she is dependent on him'*

These women expressed their independency and believed that having a strong personality with a secure job would enable them to leave their abused partners. Several informants defined financial constraints and un-employment as the main reason for staying with their violent partners:

> *(P7): 'but I believe it is all about finance; a woman without a job cannot go back to the family; I expect the job is the only granted thing in life, husbands never last for you....you know....I do not trust men...some women may consider their children, and this is the weak point in every woman'*

> *(P16): ' for me I stayed with my husband because of the financial needs, you know now; I have no job; my pension is not enough to live here with my daughter, and still he is giving us some money for his daughter to pay the rent here'*

> *(P17): 'no money to live, also women have weak personality; women raised up to accept her faith, the man; they have to accept it'*

Economic hardship was a key issue leading some informants to stay and tolerate their abused partners. Economic dependency could impede a woman's ability to end an abusive relationship. Bornstein suggested that the relationship between economic dependency and abuse is bidirectional; that is, a woman who is financially dependent might be more likely to tolerate abuse, but the abuse itself might lead the woman to be more financially dependent [315]. The economic dimension involved in IPV might be supported also by the marital dependency theory, which argued that employed women are less economically dependent on their partners and are therefore, less likely to tolerate abuse [316]. The majority of my informants who believed that employment and income are essential determining factors in women's decision to stay or leave their partners, were found to be un-employed. However, some feminist perspective predicts a higher risk of violence against employed women, which was not explored by my data, but it was an interesting comparative point to highlight [317]. The increased risk of abuse to employed women has been explained by the resource theory that sees violence as a result of power derived from an imbalance in access to resources [318]. Male partners who cannot derive power from their employment status or

greater economic resources will use violence to assert their dominance in the relationship [317]. Therefore, whether women employed or un-employed, they might be at risk of IPV.

Only one informant disclosed her emotional dependency in the early years of marriage and that loving her husband was the reason to stay with him although violent:

> *(P14):' Because I love him very much in the start, and believed that he is a very moral religious man'*

Some informants believed that the exposure to IPV was their destiny and accepted it instead of facing the consequences, such as losing their children, and justifying their failure to the society after becoming divorced women:

> *(P17):' this is my fate; he is my man and I got children from him, I do not want to look for another man; I want him to change*

> *(P18):' I do not know, there is a saying in our culture; be patient with what you have, otherwise you will get the worse, so what I can do, ask for divorce and back to my family house, this is life; it started nicely with love and end up slowly with time; I left him to do what he wants, it will end up one day, if I prevent him, he will insist, so I decided to wait and see how it will end'*

These women were uncertain, and had limited choices trying to change either their violent current relationships or leaving at all, coping with what they had, and believing that they should stand what they already had than looking for the unknown alternatives, which could be worse.

6.3.1.5.2 No place to go

The recurring idea of *'no place to go'* was mentioned by some informants describing their hopelessness and untrustworthiness in the system (society and legislations) of Saudi Arabia to protect them, as well as social and cultural restrains on women's freedom of movements:

> *(P1): 'now I have no place to go... all my things in the house, my children... I want him to go outside, not me, impossible he will keep away'*

> *(P7):' in Saudi you do not have the freedom to go anywhere, and this created problems; I cannot go anywhere as I wish'*
>
> *(P16): ' if I think to leave my husband, where I go, no place to go, better to tolerate him than going to my brother house'*
>
> *(P17): 'because there is no place to go in Saudi, no shelter to live in'*

Another informant was uncertain where to go and expressed the need to a balanced response to IPV. Furthermore, she emphasised that she could endure the consequences such as financial constrains if she decided to leave her partner:

> *(P17): 'No, where to go; I have to compromise, it is a balance, to live, you have to suffer on the other side; there is no place to go, no shelter to live in, no money to live, if I talked to my friends they would blame me; they never advise me to divorce him, people see these things normal, and they would say this is always happened between couples, but I cannot see this as normal'*

Even though my informants were not currently living in Saudi, they emphasised the lack of shelters or safe places for Saudi women in their homeland, and they were left with a choice of tolerance and acceptance. This suggested also that in addition to lack of freedom to start a new life in Saudi Arabia, this might be complicated by financial problems mentioned by several informants earlier. However, I would as well wish to appreciate the newly developed shelter houses in Saudi 2 years ago (three shelters so far), a pioneering contribution, that I had the privilege of visiting one of them in my hometown. My informants seemed unaware of these changes and hence, expressed their concern of lack of safe places for abused women in Saudi. These governmental initiatives might reflect the level of awareness of the Saudi society of the presence of IPV and the need to safe shelters to protect abused women.

In summary, this theme exploring the level of sustainability, tolerance, or leaving the partners of my informants provided different dimensions underpinning their response to IPV. There seem to be a number of facilitators (woman 'strong personality, economic independency, stable job), and barriers (family rejection, society perception, having children whom the women may lose, culture (blaming

and stigmatising) and religion (belief in God's command to obey the husband) to my informants leaving their violent partners. This might explain why the majority of informants chose to stay instead of facing several barriers. My informants considered not only their individual difficulties when deciding to leave or stay with their aggressive partners, but contextualized other familial and societal factors, such as family unity and social stigmatization if they were divorced. This is in line with my ecological framework that addressed the individual, familial, and societal influences in IPV. Hence, this would help in providing evidenced-based information to policy makers in order to plan the appropriate and focused interventions to tackle such violence.

Having discussed the theme of informants' decision-making process in staying and/or leaving their abusive partners, I will go further to explore the theme that discussed what kind of help they sought in response to IPV and their coping strategies to such abuse.

Informants' response to IPV and their help-seeking behaviours were an important issue to explore in order to identify the available community resources and to explore their views and perspectives about such resources.

6.3.1.6.1 Help seeking behaviours to IPV

During the interviews, my informants expressed a range of actions they took when exposed to IPV. This ranged from no action to various responses that were situational as explained by informants depending on a range of resources available. Informants' responses were influenced also by their beliefs and attitudes they held regarding IPV.

Initially, I will start with participants who ***did not*** ask for help. The majority of my informants kept silent rather than help-seeking or talking to anyone about their suffering:

> *(P3): 'I have to keep things inside me... I would not talk...why I should talk; I do not feel that talking will help or benefit me, I would not talk'*

> *(P10): 'No, I never speak to anybody about my private life... I never talk about my life to anybody'*

As several of my informants were not exposed to severe frequent type of IPV, the expressed experience might be just situational couple violence (as discussed previously in the being abused theme). Hence, many informants who were exposed to less violent types of abuse did not ask for help. These women, who scored and defined by the survey questionnaire (CAS) as emotionally abused, when interviewed had verified the process and situations surrounding these classified acts of IPV and seemed to be common couples' violence. Therefore, asking my informants how and why these episodes of IPV happened helped to understand why they did not ask for help. Thus, the follow-up interviews with some of my informants helped to capture whether an abusive act happened or not and subjective reality of IPV (happened once and never repeated and therefore, women did not ask for help). However, this might reflect the fact that some women might minimise their exposure to abuse, in particular, the verbal abuse due to gender inequality in roles. Furthermore, common couple violence is a contested idea and might be applicable differently in different cultures. I am also concerned that if I apply it to the situations of some of my informants, it might also lead to under-estimation of the extent of IPV and, hence, to further exposure to such violence if not discovered early and help offered accordingly.

An informant who was reluctant to seek help from the police but would justify her refusal because she respected her husband and thought she might be at fault and blamed herself, contributed the following:

> *(P7): 'I will never ask for external help, like police, because I respect my man, I should think of myself also, what I did that lead him to be violent? Maybe I am wrong; you know we are human being'*

This woman might still hold the old type of love with its self-sacrifice and the belief that man is a more valued gender by the society than a woman is.

Another informant explained that respecting her husband was her main reason for not asking for help:

> *(P11): 'No I don't like to speak about my husband to others; I love him so much, and I respect him, always; I don't want others to feel that he is bad, no I wouldn't'*

This woman might be less likely to report violence as she expressed her feelings of loving and respecting her husband and that, she did not want others to perceive him negatively. Another informant who also preferred silence was concerned about the society' reactions that may negatively judge divorced women and was fearful of then losing their social status:

> *(P17): 'No, I have to tolerate it, because society will point to you; they will speak about you badly, even me, I want to live a good life, my reputation; I need to be in a good shape, so I have to compromise; it is a balance, to live, you have to suffer on the other side'*

When an informant asked why she did not ask for help, she thought that her husband's control was a barrier; additionally, she expressed her inability to get away from such control due to her upbringing of being quiet and never complaining:

> *(P16):' I don't know; he was in control of everything, if I did he would know, I wish I can, but how can I escape from his shouting and control, I cannot... I don't know; maybe this is my manner, I never complain; I can imagine I contribute this to the way I was raised up, may be, I do not know'*

Another informant expressed her fears regarding asking for help because she could predict how her partner would act if she complained:

> *(P18):' No, because I knew my husband; if he knew that I complain he would punish me worse, that what I expect'*

Here, combination of fears arising from both the society and cultural parameters, the society, and from the behaviour of their perpetrators seemed to shape some informants' response to IPV rendering them more silent. Several of the informants did not ask for help as they might be exposed to situational couple violence. This can be explained by previous research, which found that women experiencing such situational violence were less likely to seek help than those who were exposed to a more frequent serious pattern of IPV [319]. However, a few justified

their silence and considered it as a way of respecting their partners as part of their social traditions. This was in accordance with a previous study that showed some women were less likely to report violence and abuse by their partners, if they express traditional gender-role attitudes [320]. Others wanted to ask for help but were prevented by fears from society and/or retaliation from their abusive partners. This was consistent with many previous studies, involving, for example, immigrant Vietnamese American women who expressed shame and fear of the abuser preventing them from disclosing their experiences of IPV [121]. South Asian women and Kurdish communities expressed similar fears and concerns that routinely act to silence women about their experiences of violence and discourages them from resisting such forms of control [321-322].

A few informants did not ask for help but wondered why their partners acted violently despite the love they shared between them:

> *(P14): 'No, never, because I did not understand why he is acting like that; actually I was trying to find explanation, may be excuses because he loved me and I love him; if I tell my mother, my mother is very strong; she will tell me to leave him, so I kept silent'*

This informant showed her effort to find the explanation to such acts despite the love they shared as partners and expressed her fears from her mother reactions when discussing IPV, which might conflict with her own ideas.

Some informants thought that it is their duty to fix their problem, and that they should bear their abuser in order to protect their children from suffering the consequences of IPV:

> *(P19): 'No, I never talk to anybody; I felt it is my responsibility to solve my problems,; I should tolerate them; whatever happened, I would not allow my children to suffer the consequences of such things; it is a concept what ever happened between a husband and a wife, it is not only these two are involved; we should think of other souls in the house, not only ourselves; it would affect them'*

Some informants stressed the point that talking to their family is never an option when exposed to violence and might not be of help to them because they believed

that family might either exacerbate the situation or ask for an immediate solution such as divorce:

> *(P5): 'Family cannot help, because they just interfere without any solutions; they asked me to divorce from him....only this solution...they sometime irritate him..., and I decided not to tell them anything after that'*

> *(P8): 'I can go for anybody to talk about it, but not my family.... I do not want them to perceive him badly; they like him and I do not want to change this perception'*

These informants seemed to internalise their suffering and stayed with their partner rather than telling their families that might perceive the partner as a bad person.

Another informant emphasized the point that talking to a religious figure for an advice could solve the problem without family interfering:

> *(P9): 'if it is really needed, she has to go to a trustable person, not only being a brother or sister makes them trustable; she needs to select very trustable one, even religious figures of the society would be enough to ask them over the phone what I have to do, this could be enough; it does not need to be a very close member of the family'*

Having discussed informants who did not ask for help and the reasons behind their reluctance to seek out help, I will now talk about those who sought help from different resources such as friends, families, health professionals, and police.

One informant would talk to friends about her exposure to violence but after a period:

> *(P11): 'I may talk to my friends after long time after the occasion like two months just to share my life with them, not because I need their help'*

This woman chose to talk about her problem with IPV but after a period, which may reflect their need to emotional support, understanding, and listening from others rather than a help to solve their problems.

Another informant talked to her friend looking for some guidance and possible solutions to her IPV, rather than needed a help:

(P18):' May be friends, but to talk, about it not to ask for help, but to find some solutions, advices, like that'

A few informants asked for help from their family, particularly their fathers or uncles because they believed they are sensible and calm. However, if they decided to go back to their family, the informants' families might not accept their children:

(P15): 'I told my father about his behaviour, but my father refused my children and said; I accept you but his children no, and my children are my weak point; I cannot live without them, so I stayed with him'

(P20): 'I told my dad and uncle, because they are wise and quiet'

While another young informant, who was married to her cousin, used different tactic asking help from her uncle as he was the father of her husband, and this facilitated the help-seeking process:

(P6): 'For me, I would involve the family, my uncle, unless it is dangerous issues, which I cannot imagine right now, I still believe family has a strong influence on the husband'

Help from health professionals is often considered one of the possible channels that could provide help to women who are exposed to IPV. Some of my informants had different reasons for asking for help from health professionals such as asking for comfort by talking to their GP about their feelings or to find explanation:

(P1): 'I went to a psychologist, not asking for help, but to advise me how to deal with it... I rather solve it with him than they interfere, this will allow me to reserve my dignity in front of my family....I do not want them to appear as if they saved me; as if I am broken'

(P9):'If I need I would not ask them to solve my problems but to give me some advice ...consult them...I expect for things that I have no answer to...then I would take it or not'

(P12):'Not directly, I asked my psychologist friend trying to find explanations for his behaviours, but not to intervene'

(P20): 'I did go to the GP but not looking for help, but for advice what to do, I was going to explain what happened, to talk to anybody about my feelings'

Another informant added that talking to a psychologist made her aware and insightful about herself:

> *(P14):' I started to see the psychologist; she was really very helpful; she opened my eyes; she woke me up, and I was blind'*

An informant looking for explanation and understanding not only to her husband's behaviours, but also to herself:

> *(P20): 'I also went to a counsellor to find explanations and to understand myself and my husband'*

These women sought help from health professionals asking for advice, rather than wanting them to solve their problems with IPV. Another informant who was affected by her abuse explicitly asked for help from a psychiatrist, as she perceived herself as being depressed:

> *(P4) 'I consulted a psychiatrist because I was depressed and unable to talk to anybody about it'*

A young informant, who was not fluent in English and was not sure she could find an Arabic speaking counsellor in the UK, had sought help from a marriage counsellor who lives in Saudi, but through the internet where she talked to him using the Skype software to discuss her problems:

> *(P5):'I consulted a marriage counsellor via the internet...she clarified how relationship works between couples...directed me how to behave'*

This woman asked for help using a distant source, which allowed her to clarify issues related to marital relationship and how to deal with them.

Although some informants asked for help from friends and/or family, a few informants sought help from a psychologist, a counsellor, or psychiatrist seeking emotional support and/or advice but not for intervention. They wanted to find explanation and/or to express their suffering. This was consistent with a previous study that showed that abused women did not expect or want health care providers to fix their situation [323]. It highlighted that some abused women can manage their lives if listened to by friends, families, and/or health professionals.

Therefore, understanding these needs would help to locate help resources to the most needed women groups.

Additionally, some informants' acknowledgment of the importance of health care professionals, in helping them addressing their feelings, was similar to the findings of a meta-analysis of qualitative studies that addressed how women with histories of IPV want their health care providers to respond to their disclosures [324]. The authors addressed that women's feelings about IPV were different and influenced their decision in discussing their problems with particular health professionals in certain situations.

It was only one severely abused informant who made it through to the accident and emergency department of the hospital (in Saudi) for help and to alert the authorities to the incidence for future evidence:

> *(P17):' I went with the driver at 7 in the morning to Accident and Emergency, because I want to document it, the ER doctor called the police and documented the violence'*

Asking for help from public services such as the police is another source women could use to protect herself. One informant, who was raped by her husband, chose initially not to report it to the police. Such response might reflect the lack of awareness of the seriousness of her situation. This was possibly done in order to survive in the immediate present and avoiding her children holding her responsible in the future if she decided to proceed accusing him for the rape. Eventually, she sought help from the police but half of the story was still a secret with her, as she did not disclose the rape act but only the harassment by the husband:

> *(P14):' we discussed the matter together I and my brother and consulted a friend; he helped us by the information on how to ask for police help, I was a bit reluctant to go to the police because I did not want my children to blame me in the future and say that I put their father in the prison, so I refused to go for police, but after a few days when I missed my children; I could not wait, and I asked my brother to go with me to the police... , I decided not to tell them about the rape, but about the harassment and that he prevented me to go outside... , because I came to know that he will be charged and may be put in jail, and I cannot do that to the father of my children'*

This woman believed it is inappropriate and against her family values to do so for the father of her children. However, some women might minimise the abuse especially the verbal one because of the influence of the strict cultural role and discriminations against female.

The last two informants sought help because one was raped, and the other one was severely injured; this finding lends supports from previous studies, which found that severely abused women were much more likely to disclose the violence asking for help because of the need of health intervention to manage the trauma and fear of death [325-326].

A few informants who did not reveal seeking help, were asked whether they would go to ***any*** health professionals if exposed to partners' violence. An informant who trusted the judgement of a health professional said:

> *(P10): 'I believe counsellors could help because they judge things by their mind not emotional like with the family'*

This woman emphasized that counsellors could help professionally with IPV, as they could view the situation and interpret it in a rational manner without being emotionally driven as might happen to a family member. Another informant listed the possible sources available in Saudi Arabia and pointed to the helplessness of these resources and that God obviously was the only accessible source for help to a Muslim woman:

> *(P16):' psychologists; they can advise and explain things, but they cannot interfere; I mean here, in Saudi nobody can help, even judges or even lawyers, nobody can help, even if you try to ask for your simple rights, you will not succeed, nothing, only God can help you if you pray him'*

She acknowledged the importance and usefulness of advices by a psychologist that she approached regarding her abuse. In addition, she highlighted the lack of help to women in Saudi Arabia when seeking support from different societal sectors (judges and lawyers). Various Saudi societal and legal sectors have no pre-defined regulations regarding the help-resources and no written civil law instructions in place when women exposed to IPV (see further detail in the discussion, section 7.4.4.2)

Although several informants were certain about what and why help was needed, some were not sure where to go and yet uncertain how to disclose IPV to their doctors. They were not confident that the doctor would understand or even help them in dealing with IPV:

> *(P1): 'I do not know; family; no may be social services; I am not sure, legal action is the one may be'*

> *(P3): 'I was not sure where and how to tell these things to my doctor...I am not sure whether my doctor can understand and help in this matter'*

However, some informants could not see the reason for asking for help from health professionals:

> *(P1): 'because no one can help; they cannot do anything, what they can do...If I go to G.P, what I will tell him? Come and help me, someone abused me; abuse is not always, then if it is very risky I will call the police'*

> *(P18):' Not at all, ever...because nothing is serious, I do not need them [health professionals], why should I ask for help, nothing important'*

Informants did not perceive the need for help because they felt they had found to be either not been exposed to a serious type of IPV or did not believe that health professionals could help. Again, another explanation could be their strong belief that God is the only source of comfort:

> *(P4): 'I think God was with me and the only one who gave me strengths to live....every woman should work hard to strengthen the connection with God....pray him and ask for help...I do not see medicine can help...I mean tablets...never helps me'*

> *(P13):' I go to God; I mean I speak to God; I pray for him; I also speak to him'*

Married couples reported that praying to God about their conflicts increased their sense of responsibility for self-change, reduced emotional negativity, and facilitated perspective taking, empathy, gentle confrontation, and problem solving [327-328]. Mahoney has pointed out that diverse religious traditions offer couples spiritual resources to resolve the inevitable conflicts that may arise in marriage

and can escalate to IPV [329]. In this qualitative study, researchers highlighted that an inner sense of spiritual support from God can empower victims of IPV to leave an unrepentant offender. However, a felt obligation to God can encourage victims to remain attached despite the personal cost. Some of my informants expressed this sense of obligation to God and although they have a different faith (Islam), compared to participants in the literature that I referred to (Christian and Jewish), they prayed to the same God and possibly shared the same nature of spirituality. These studies illustrated that survivors of domestic violence from religious backgrounds seem to transform their spiritual expectations of the roles of husbands and wives in marriage and draw on faith as a resource to leave or reconcile with an offender [330].

Generally, some of my informants, spontaneously, described their perceptions and views about the help-seeking behaviour that women should think of and conditioned it to the type and severity of violence they exposed to:

> *(P10): 'I think if it is physical violence, she should go for the police, or court; she should not keep silent, but if it is like my case, they should discuss between themselves, nothing very serious'*

> *(P18):' if physically affected, women should ask for help, but not interference from the police, no this is a very strong interference; I do not like it; it depends on the situation as well'*

These informants specifically emphasized that women should ask for help if physically abused by their partners, and if the abuse was not serious; they could discuss their problems between themselves and their partners. This suggested that some of my informants might have different understandings and definitions of what constituted IPV compared to instruments such as the CAS. For example, marital rape, some of my informants did not define the forced sex is a rape (see further discussion of this point in chapter 7).

6.3.1.6.2 Informants coping strategies to IPV

Coping strategies to IPV are women's attempts and ability to deal with their exposure to IPV. This might include active strategies such as looking for solutions or expressing emotions (crying) in response to IPV, or passive strategies such as accepting that nothing can be done to resolve IPV.

Informants coped with their IPV exposure by different means. The notion, which dominated the narratives of several informants, was their preference of keeping quiet or/and crying the moment they were exposed to IPV:

> *(P11):' sometimes I cried, or keep quiet; I never shouted like him, never; I have a belief that respect is everything in marriage life, yah; I feel disgusting, nauseating, from the way he would say some words'*
>
> *(P13):' I just stayed in my room and cried, nothing; I slept after that'*
>
> *(P14):' I was shocked, speechless, I cannot say a word; I just cry'*

These women expressed their belief that keeping calm and not outcry are courteous in response to their aggressive partners. Some informants coped by escaping IPV in various ways such as crying, sleeping, and praying to God. Others expressed their trust in their partners and that their behaviours (shouting, swearing) were then unexpected making some informants confused, to be wordless, and uncertain:

> *(P15):' I just keep quiet; I feel shy to say anything; I never doubt his behaviour, never thought it is negative things; I was not expecting bad things'*
>
> *(P16):' Nothing, I do not like to speak; I like to be quiet... I don't know, maybe this is my manner; I never complain, I can imagine I contribute this to the way I was raised up, may be, I do not know; even I did not ask him why he was sleeping in a separate room, for the last seven years before we separated'*
>
> *(P19): 'I would keep quiet even my husband is shouting and angry, if I have to do something; I will go to my room and pray God, that's it, nothing more; I don't like to enter a debate or start arguments'*

Another informant was silent because she feared the worse from her partner or even death. This woman felt that even if she attempted to cry, she might be exposed to more violence from her partner, and expose her children to an unsafe behaviour from him:

> *(P17):' I was silent; I have to keep silent, you know why, because if I even cry, he will continue beating me up; he could do anything, anything, can kill*

me, so I preferred to calm it down and silent instead of risking my life and the children too'

One informant deliberately kept silent rather than speaking to her mother about her husband's violent behaviours because she recognized that it might affect her negatively:

(P3):'I did not tell my mother about my husband, I don't want to bother her as I am very far from her, so I have to keep things inside me...I know it will affect me badly'

One informant metaphorically reported her coping mechanism to IPV putting herself in the same situation of the great lady Mary, mother of Jesus, who had to face her family after delivering Jesus without marriage, and as she had no answer, she kept silent (This story was cited in the Qur'an):

(P9): 'he was shouting for no reasons when I sat with my friends in my house one day...I am very sensitive, and I kept silent because I did not know what happened you know it is like the great lady Mariam [Mary], mother of Jesus when she was asked how she got pregnant with Jesus without being married to anyone, you know like that, speechless'

Although some informants coped silently with their exposure to IPV, several coped actively by expressing their hopes to negotiate or discuss the violence with the partners. These women found negotiation and rational discussion with their abusive partners were unsuccessful and discouraging:

(P12):' my discussion with him if I did not like some of his commands, always rational, trying to be logical but did not work with him, eventually his idea should be applied, anything I asked I will never get it'

(P15):' I started to negotiate with him, tried to understand him, but it was emotionally driving me crazy'

(P18):' I have tried to negotiate and discuss with him, but he would make me wrong and he did nothing, but he is good'

Some informants tried to find the explanation for their partners' violent behaviours as a cognitive strategy of enduring and intentionally might lack the

awareness of the seriousness of the situation in order for them to survive in the immediate present:

> *(P3): 'I tried to change myself...tolerate him...ignore small issues...hide my anger...think of the positive side of him'*
>
> *(P5): 'I started to live my life and ignored him...started to think of myself and my child...I recognized that life is not only husband but there are other things to enjoy....I kept myself busy...I go on with life...I felt independent'*
>
> *(P12): 'but I was trying to find explanation; I asked my friends who were married before me and they said; it is always like that, marriage never without problems, until you know each other, it takes time, one friend said; nobody is happy in marriage; the idea is to have children and to continue life like that'*
>
> *(P14): 'I started to say no to him; I would go for my work; I would ignore his anger, even if he ignored me, I ignored him, why should I bother; life will continue without him'*
>
> *(P15):' I tried to keep myself busy; I do painting in the house sometimes, or do other activities for my children, keeping myself busy, you know, to keep my head distracted, so I managed until the children became adults'*
>
> *(P17): 'I have to plan my life and my children life in a safe house; this is to keep my dignity, without the need for him or my father or anybody else'*

Some informants survived by normalizing marital problems as they found out the same problems were happening to their friends. On the other hand, some adopted an escape strategy by keeping themselves busy with other activities such as painting the house and bringing up their children. These women seemed to use what is called disengagement coping response, such as avoidance and denial confirmed by previous studies carried out on abused women who felt hopelessness after being exposed to IPV [331-332].

Others challenged their abusive partners and refused their control of many aspects of the women's life. Another informant coped by calming herself in the hope that he might be less violent and describing her vulnerability during pregnancy. She said:

> *(P2): 'I started to control my moods by trying not to provoke him or blame my moods on pregnancy. I tried hard to adapt myself to be as normal during*

pregnancy as without pregnancies. After the first two pregnancies, I worked harder to become calmer'

As expected from Saudi females with a deep sense of religious background, these women would respond spiritually to IPV by praying to God:

(P4):' I feel that the only thing that made be patient and tolerated all these years with my husband is being near to God....praying and asking for help from him....God is great....I felt strong to go forward and continue'

(P11):' I feel comfortable when I think & pray God to make our life peaceful and not to have problems'

(P13): 'I read Quran; it relieved me a lot'

However, a few took more active response and left their partners, asked for divorce, or legally assigned a lawyer to escape from their miserable life:

(P1): 'I asked him to divorce me... I repeated to him twenty times that I do not want to live with you... I want to get rid of him, to end this misery'

(P4):' I reached this stage when I recognised that what I was doing is wrong...now I decided to leave him'

(P12):' I felt unsafe, why should I continue like that, so I decided to leave him, and thanks God it was an easy divorce; he did not object, and now I am free here and enjoying my study'

(P15):' I assigned lawyer and got my freedom, it was hard, difficult time, but I have to end it; I have my dignity back; I want to live my standard for myself and my children'

(P17):' I was trying to escape that day; I was hardly can close my lips together, not to say anything, until he slept, I have to use my intelligence to live, although I was broken physically and emotionally'

Informants who decided to leave their abused partners found it a difficult process to pursue, but it was a rewarding step to them as they obtained their dignity, freedom and safety back to them and their children.

Some informants expressed their partners' responses to them leaving as dramatic and apologetic in an effort to prevent them from leaving them:

> *(P1):' whenever I want to go; he will make it a drama; I mean pulling me, take my bag, feeling sorry and cry sometimes; he always promises me he will change; he always mentioned that he loves me and asked me to try again'*
>
> *(P12):' I asked him to divorce me, he apologized and promised not to do that again, I believed him; I know; I was stupid, but he swears to God; he will never upset me'*

Abused partners' response to their female partners leaving them was sometime active. For example, they might use their physical power to stop it, was accompanied by expressions of love, and promises not to return to their violent attitudes. In response to leaving them, some partners acted aggressively. This has been explained by a previous researcher, suggesting that individuals whose attachment needs have been frustrated throughout their relationship and who feel particularly vulnerable to the potential loss of an attachment figure, may strike out violently to regain proximity to an intimate partner [333]. During separation, some abusive partners might try to regain control, this creates tension, and outrageous response when women decided to leave them. This might reflect the tension between the control that some men had before separation and their lack of control when women decided to leave them. Therefore, women must be warned and be aware of the risks of their decisions, and informed of help resources in such situations. Men also need to be informed of their rights and duties towards their children and their safety and stability.

In summary, the responses my informants decided to take in reaction to their exposure to IPV were variable. They ranged from counselling approaching various health professionals, seeking help from a police, family, or friends, to a helpless response of '*no place to go*', where women did not have alternative places to escape their abuse, to the inner self, where women suppressed their anger and kept silent. I would like to represent symbolically three types of response to IPV. The first one was the ***zero response*** where the informant did not make any response to their IPV because they either could not see the need for help or did not want to pursue for it. These women expressed different reasons for their non-responsiveness such as fear of more violence from their partners to themselves or their children and economic hardship. The second one was the

conditioned response, where informants asked for help or advice but did not expect others to fix their problems with IPV; rather, they wanted to talk about it to friends, health professionals, or God in order to ventilate their stress and look for explanation. The third one was the ***need-driven response***, where informants perceived the seriousness of IPV and needed help (from father or other family members, health professionals, or other societal legal sectors).

Many of my informants coped with IPV in different manners. The majority kept quiet, cried, and/or prayed God. Some ignored the abusive partners and engage themselves with other life activities. Some expressed hopes to negotiate with partners, while others challenged their abusive partners and ended by divorcing them.

These findings in this theme provided insightful understanding of the available resources to help Saudi women who were exposed to IPV. They might reflect only what women knew about these resources or the lack of them, and hence, could be used to encourage setting up future plans and to locate helping resources appropriately for these women.

Following exploration of the theme describing the informants' response to IPV, the next theme will discuss informants' views on how to face the problem of IPV and whether they think, it is a public issue to be considered and talked about or whether it should be discussed privately between partners and their families.

This theme discussed the informants' possible means that might help in overcoming challenges they faced when exposed to IPV. They expressed that discussing IPV openly in public and anonymously using the media is better than discussing it privately between the partners themselves or their families behind closed doors. Furthermore, informants suggested several solutions to the problem of IPV at the individual and societal levels.

6.3.1.7.1 IPV as public Vs private

IPV has shifted over the recent decades from being considered a private problem to being recognized by several international organizations as a public health concern with serious consequences for the women's well being [334]. Informants

were asked whether IPV should be discussed privately between partners or their families, or debate IPV as a public issue. This was done in order to inform future development of preventive and interventional measures to tackle IPV. The majority strongly thought that they are part of this world and should share their problems with the rest of the world, in order to help solving them. Some informants believed that their voices should be heard regarding the issue of IPV, and there is a need to discuss it more in public and raise awareness of the issue:

> *(P5):' I believe it should be discussed publically; we should be brave to raise our voices...it has to reach the society'*
>
> *(P7): 'it is a social problem and needs to be discussed but anonymously, of course, if we keep silent, this will never be solved, because it will affect children, the whole society, we are trying to build...even if we did not find radical solutions, but at least to raise the awareness of the society members about it, to avoid it in the future'*
>
> *(P8):' it should be discussed publically to solve the problem...so the society would be aware of it, and that it could lead to broken families, we would lose out community ties because of us not controlling our anger and emotions, even for children, they will be really affected emotionally, even physically'*
>
> *(P9):' it should be discussed frankly in the society, so we can find solutions, but I believe without names, not like what is happening sometime in the news paper; some women will talk about their problems if she is known to the media, she is using the media, No...this should be discussed objectively in schools, in the TV as a general subject....lectures should be given to couples about how to deal with each other, how to respect marriage, we need this'*

These women suggested several activities on how to prevent IPV. The suggestions were related to the different levels of societal organization, comparable to the different levels in the ecological model underpinning my thesis. This involved suggestions at the individual level by educating women about their rights and duties in intimate relationships. At the societal level, several informants suggested that school education, during childhood, on how partners should communicate is essential in building up good behaviours.

Although many of my informants believed that IPV should be discussed in public, they emphasized that this should be done anonymously to preserve the privacy and confidentiality of not only the individuals involved, but also their families:

> *(P10):'I believe it should be discussed publically; I mean now it is increasing, very noticeable in our society; women are victims and need to be helped, women now, however, are stronger; they speak up their mind, our mothers long time ago really were very patience, now they ask for help; their voices are loud, yah things are changing now'*

> *(P13):' I believe we should talk about it in public, in the TV, in schools, but without names, because especially in our society it is not acceptable to speak like that about your husband'*

> *(P20): 'publically it would be usefully to discuss especially those who think that it is a normal couple thing, not to talk about it to one person or a friend because women would not be honest to tell everything, because confidentiality is never guaranteed, we still a culture that is trying to protect their social shape, the family, we don't want others to point to us and labelled as abused'*

These women expressed also the importance to consider and be sensitive to cultural norms that shaped the society. One informant explained why IPV should be discussed at public as violence of this type has started to be obvious in the Saudi society and women are the victims who need help. She highlighted an example of the present changing Saudi society as women became stronger and expressed their views compared to previous women generations '*our mothers long time ago*' who were more tolerant to IPV.

The majority of my informants linked that discussing IPV publically would inform the society and help in negotiation of solutions. However, one informant held a conservative view believing that IPV is a private matter and reasoned this by the fact that Saudi society is considered a conservative society and this would not solve the problem if we decide to discuss it publically:

> *(P6):'I believe it should be discussed between families privately, because no women would like to point to her as abused, but we can talk about it generally publically without mentioning names....I do not like these women who exposed to violence to mention their names and stories to a newspaper...this will not solve the problem in our society, our society is very conservative and this breaks it...we should teach our male children in schools how to respect women, then when they grow up, they won't be violent'*

However, she did suggest that IPV could be reduced in future generations by teaching children in schools the concept of respecting women in an effort to change societal norms.

6.3.1.7.2 Solutions

During the interviews, informants spontaneously suggested solutions to IPV. Some suggested that educating women not only about their rights and to how to defend themselves, but involving the whole society in the education and knowledge about IPV. My informants thought that societal awareness and change would be the way forward to prevent IPV transmission culturally and habitually from one generation to another:

> *(P13):' I believe educating these women about marital relationship is very useful; women should be strong to face it'*

> *(P14):' to educate women about their rights, about the divorce process, as Islam allowed us women to ask for divorce without giving reasons to the judge in the court, a lot of women, they do not know this fact, also our children in the school I mean when they are like 9 or 10 years old, they should be taught how to respect female; they should actually be informed about the violence itself, how it affects the family, and that they should not use violence, nowadays children in Saudi are allowed to watch violence games, no restriction, families are not educated about this, because children watching violence will use violence in their life when they grow, like that'*

> *(P18): 'women should be educated about how to deal with the husband; it should be in the curriculum of the school'*

Some informants suggested that education and media could be used to influence attitudes. They proposed that early education in the schools about marriage life and how to communicate with each other could prevent future problems in adult relationships:

> *(P15):' I think couples should be educated about marriage life; each one should be informed of his rights, even early in schools, when they are children, so they grow and know how to deal with each other, leaflets should be put in every place, even in public places, with advices, to increase awareness'*

Some of my informants also suggested a wider approach by producing leaflets in order to increase people's awareness about IPV. Some informant gave an example from other countries' experiences in the form of courses for couples before marriage:

> *(P19):' I believe women should be informed and educated and independent, and never to expect a lot from a husband, I like some ideas applied in Malaysia where the newly married couples before marriage they provide them with courses about how to deal with each other, this is education, to prepare them for the new life they are going to live; it is like preparing for a war between two nations, there are tactics, negotiations, compromises, fighting sometimes, like that, so both should be prepared emotionally and mentally, they should be taught how to control their anger, to decrease their expectations to a minimum number of demands, especially with the new girls' generations they imagine marriage life is rosy and romantic all the time, it is not like that'*

The same informant thought also that the presence of sufficient sexual satisfaction between partners is an important issue and impact on their lives preventing IPV, and that it is a mean to a happy life but not an end by itself:

> *(P19):' is the sexual relationship between the husband and the wife, if this is solved everything would be solved; it is very important, if the man is satisfied and fulfilled sexually he would not criticize the woman for other daily life things, if they are understanding and communicating with each other sexually, they would ignore small things happening in life, this is the secret and backbone of the marriage life; if each of them understands the need of each other, they would live a happy life, if not present it will lead to a series of problems; it is called intimate, and if we cannot manage this intimate relation, how can we manage the rest of life; I see this sexual intimate relationship as a mean to the life not an end by itself, God gives us this pleasure to enjoy and live life, why not to live it'*

This informant suggested that a lack of sexual intimacy might create tension between partners. Therefore, she suggested that fulfilled sexual communication might prevent IPV.

Another informant emphasized that ensuring women's strong personality when they were in the childhood and not accepting IPV would be the key solution to IPV. However, she highlighted that women need to be empowered, but remained accountable about the house, their partner and the children:

> *(P20):' we should build our daughters' personality to be strong; I believe the violence allowed by the women in our culture, if she allowed him to do so from the first night... women should be empowered but fair, on the contrary, women should also responsible and care about the house, the husband and the children'*

This informant suggested that some women's acceptance of IPV in the Saudi culture might permit a continuation of such abuse by the male partners. Therefore,

she emphasised the importance of empowering women earlier in their lives in order to prepare them for future intimate relationship.

These suggestions by my informants were in line with previous researchers who emphasized that education programs which are intensive, lengthy, and use a variety of pedagogical approaches have produced lasting change in attitudes and behaviours [335]. One approach, authors suggested, could be established by encouraging an ethos of non-violence in the classroom and in all aspects of the school, and introduction of content on violence into the teaching materials. A good example is the White Ribbon Campaign, which is the largest collective effort in the world focused on involving men in ending men's violence against women [336]. It is a school-based campaign established in Australia focusing on the positive roles, which men can play in helping end violence against women. Empowering women earlier was suggested as one of the preventive strategies to future exposure to IPV in marriage time, as they grew strong and informed of their rights and duties as mothers and wives.

In summary, to overcome the challenges faced by my informants, the majority believed that IPV should be discussed publically generally but were very concerned about the confidentiality and the possibility of breaching of societal norms. Educating children in schools, increasing awareness of IPV in the society, and informing women of their rights, were key elements in discussing IPV in the public domains (media and TV).

This theme informed our understanding of the possible strategies explored by informants and backed by examples from the literature. Therefore, it offered challenging opportunity to learn from other international experiences in tackling IPV and to follow their footsteps with special consideration to the changing social and cultural aspects of different societies. This need to be done in a culturally sensitive and appropriate manner.

Having explored the theme of my informants' views on how to overcome IPV and its challenges, their feedback on the questionnaire posted to them before the interview is discussed in the following section.

This last piece of the interview was very interesting and provided very useful information and critics to the survey posted to these women and added fruitful comments regarding the interviews. Most of my informants reported a number of advantages to participating in the interviews including, being given a voice, sense of relief, healing, and being provided with a sense of purpose.

With regard to the survey, the majority of informants commented positively about the appropriateness and clarity of the questions and its wording. However, some did not feel it was reflecting or represent their status at the time of the questionnaire:

> *(P17): 'it was easy to answer, but sorry to say; it does not reflect my experience; it does not ask about what we are exposed to, some women would also fear to say the truth, because it is not safe, so I don't think women told you the truth, it is difficult to speak about it, very difficult subject to discuss, and women are not speaking up, so it needs to be raised, women empowered to speak'*

> *(P19):' want to tell you first that when I answered the questionnaire; it was the last year, my 1st year in the UK, and it was very difficult so it does not reflect my situation now'*

> *(P19): 'it was not clear for me some of the questions, why you are asking these questions, I did not see that connection but when you talked to me today I can see what you are trying to know I mean I can understand the subject now, but in the questionnaire; things were not clear to me, I don't know'*

> *(P20): it was not bad, not very interesting, because it does not ask about the types of things Saudi women facing, it could be ok for women who are exposed to clear defined type of abuse, but for women who are exposed to more damaging indirect violence cannot be discovered by this questionnaire, when I answered it, I felt my life is ok not bad, but the type of life I am living is not represented by these questions, or does not reflect my suffering with my partner that I am exposed, the types of abuse I am exposed to cannot be extracted by this questionnaire'*

These informants highlighted some important aspects regarding the gap between answering the survey and having the interview, indicating that their answers to the survey did not necessarily reflect their situations at the time of interview. While some could not even remember their answers to the survey, other, however,

mentioned that it was not sensitive to reflect on the kind of experiences they were exposed to. Some did actually recognise the connections that were addressed in the questionnaire, and the discussion carried out in the interviews and stated that they became more aware about their situations when were asked the 'why' and 'how' questions regarding their relationship with their partners. I will explore these issues in details in the discussion chapters.

After discussing the emerged themes of the interviews, I present some thoughtful explanations linking the themes in the following section.

6.3.2 Explanatory account

In this section, I will focus on the wholeness of IPV experiences rather than a single individual issue in relation to IPV. In the discussion chapter, I will discuss the findings from the interviews in relation to my survey results to fulfil my conceptual framework objectives underpinning my thesis. Experiences, beliefs, and behaviours are integrated and inseparable relationships between individuals and other surrounding realities. The explanatory account here depends on meanings rather than specific behaviours related to IPV in an effort to generate patterns and understand informants' experiences of IPV in their social, cultural, religious, and political contexts. This explanatory integrated approach is in line with my ecological framework that explained IPV at individual, familial, and societal levels.

At the individual level, the majority of my informants believed that IPV is all about control and/or partners degrading them. However, some informants thought that what were happening to them were normal couples' arguments or conflicts that led occasionally to infrequent physical aggression with a few. Additionally, it was observed that majority of younger participants (<40 years old), that were exposed to severe combined abuse and/or emotional abuse± harassment, and sought help from a psychologist to provide support and advice. While some informants who were silent were older in age and abused emotionally. Most of the younger informants either had initiated or jointly initiated IPV events, compared to older informants who were exposed to IPV that was initiated mostly by the partners. This suggested that social changes of empowering women among Saudi

are coming into sight nowadays, giving voices to the young generation and hopes to those who still see silence is all what they can do.

Most of the informants who were exposed to severe types of abuse, such as rape, separated from their partners or divorced. While emotionally abused and harassed informants had stayed with their partners longer and they justified it by various reasons (what is happening is just a couple mutual violence, hope that the partners will change, nothing serious, and fear of stigmatization of divorced women by society). The majority of the informants who were exposed to emotional abuse, expressed more psychological impacts such as loss of concentration, anxiety, stress, low mood, and crying, while participants who were exposed to physical and severe combined abuse expressed more physical symptoms such as fatigue, headache, and loss of appetite. Despite all, and regardless of the type of abuse, many informants did not ask for help, and if they decided to involve someone such friends, or professionals, it would be just for advice and wanted someone to listen rather than fixing their problems.

At the family level, informants explained that being in the UK was an advantage to several women in many aspects. Many informants expressed their comfort and improvement of relationships with their partners because they were away from their families interferences that provoked IPV to some of them. However, for a few, relative marriages were protective as the family ties could prevent IPV from happening. Some informants believed that being in UK was stressful and too liberal, and they felt isolated.

At the societal level, almost all informants (except one informant) believed that it is a matter of culture and social value that enforces the rigid gender role and facilitates IPV rather than religion. Therefore, the majority expressed the various challenges that they faced from the societal and cultural values and norms that imposed on Saudi women for ages. In order to change these deeply-rooted social norms, the majority of informants suggested that education of children at school, use of media to raise awareness of the society at large, and empowering women could be the solutions to prevent IPV in future generations.

My participants' response to IPV was influenced by many factors at the individual, partnership, and societal levels. These levels interacted in different situations, for example, some women might not ask for help due to fear of further abuse (partnership level), lack of income (individual level), and strict gender roles in the Saudi culture that made women responsible for men's behaviour (societal level).

Findings from the interviews, which for the first time explored Saudi women experiences of IPV in the UK, revealed a rich insightful understanding, perspectives, and views about such violence. These findings will be integrated with my survey findings in order to reflect the breadth of IPV among Saudi women. In line with my ecological conceptual framework, I will discuss and incorporate the descriptive and explanatory findings, and their implications combined with the survey findings in the following discussion chapter.

Chapter 7. Discussion

7.1 Introduction

In this chapter, I summarise the findings of my studies starting from the translation and adaptation of the survey questionnaire to the outcomes of the survey and the qualitative interviews. I then discuss and synthesis the findings of the three studies in relation to the literature and in the context of the overall conceptual framework of the thesis. To accomplish my objectives of estimating IPV prevalence, the socio-demographic profiles, the associations between health and IPV, and exploring experiences of IPV among Saudi women in the UK, I linked components of the survey and the matching themes that emerged from the interviews to triangulate the different types of data within the ecological conceptual framework of my thesis (chapter 3), looking for similarities, as well as, discrepancies. This approach is consistent with Curry and colleagues concept:

> *The state of the art is to recognize an array of potential factors related to IPV, and to organize them based on where they could fit within an ecological context.(p.61)[337]*

However, some of the interview' findings could not be ***directly*** linked to survey findings and discussed separately within the ecological framework. For example, issue of religion was discussed in the interviews, nevertheless, could be linked to other issues asked by the survey. Examples of these issues are discussed below.

7.2 Summary of results

The results of this thesis were generated from three studies (Table 7-1). This allowed accomplishment of my thesis objectives. The first objective was to translate the CAS and to adapt the whole survey and the accompanying information sheets which, was fulfilled by the ***first*** study (chapter 4). This adaptation and translation process resulted in a refined version of the survey questionnaire.

The second and third objectives were to measure different types and severity of IPV among Saudi women in the UK, their socio-demographic profiles, and their health status, which were possible by conducting the ***second*** study (chapter 5: ***survey***). The survey showed that the severe combined abuse was the most common type of IPV among Saudi women living in the UK (19%), followed by the emotional abuse and/or harassment (11%), then the physical, emotional abuse and/or harassment (3%), and physical abuse alone was 2%. Participants were relatively young (31 years), highly educated, and the majority were currently in an intimate partner relationship (76.3%). On average, these women had lived in the UK for three years and had been married with their partners for 10.4 years. I used logistic multi-variable regression model and included the following factors: women's education, partner education, length of marriage, length of stay in the UK, women' age, having three children or more, and afraid of partner. Regression analysis showed significant associations between various types of IPV and some measured explanatory variables, which were that women exposed to severe combined abuse often had a lower education level, were married to partners with lower education level, and were fearful of their abusive partners, compared to the non-abused women. Emotional abuse and/or harassment were significantly associated with having three children or more, after controlling for other confounders (mentioned above). A lower score of SF-36 in all its items was significantly associated with exposure to severe combined abuse. A lower score of only emotional well-being item was significantly associated with emotional abuse and/or harassment. The fourth objective was to explore Saudi women experiences of IPV, which was fulfilled by conducting the ***third*** study (chapter 6: ***in-depth interviews***). This provided rich diverse accounts of IPV. I purposely sampled from the survey respondents; therefore, I managed to get a diverse sample in terms of age, location in the UK, and different types of IPV.

Six main themes emerged from the interviews. The first theme involved Saudi participants' description of IPV that described the process and progression of violent episodes that were mostly verbal arguments in nature and were infrequent if such episodes were a sever type of IPV. Its initiation was explained by many

informants to be sometimes from the participants themselves, their partners, or both. Data suggested that IPV for most of the participants was all about male partners' control over participants. The second theme was the bio-psycho-social impacts in relation to IPV where participants expressed various symptoms of headache, long standing general fatigue, loss of appetite, and nausea, feelings of stress, anxiety, fears, low mood, lack of concentration, suicidal thoughts and attempt, and some felt isolated and lost their interest in life and work.

The third theme was about my participants understanding and beliefs about IPV. They expressed different understandings and definitions of IPV, in particular; they emphasized that control by the partners and emotional abuse were considered more abusive than the physical abuse. Definition of IPV by the participants involved not only the acts, but also the impacts of such acts on their well-being. They expressed several individual, familial, social, religious, and economic-political factors that acted as facilitators or barrier to IPV. Husband's childhood, being abused as a child or witnessing their parents being abusive, was mentioned by several of my participants as a reason for being violent with them. Being in the UK was helpful and protective to several participants, while for some, it was stressful and associated with a sense of isolation.

The fourth theme was help-seeking behaviours and coping strategies participants sought during or after IPV incidents. Their response was mainly silence, as they did not discuss the abuse with anyone. This could be a coping mechanism, or could be because they did not see the behaviour as abuse or might have been frightened and felt they could nothing about IPV. Some sought help from friends, family and various health professionals, but for support and advice rather than to solve their problem with IPV. Some participants thought that coping by crying, praying to God and finding explanations for partners' aggressive behaviours were enough sometimes; others took more active roles and left their partners, sought help from the police, or health professionals.

The fifth theme was the different reasons that influenced participants' decision to stay or leave their abusive partners. Reasons were mainly their fears of losing their children, challenges in facing the society stigmatization regarding divorced women, and financial constraints. No place to go was a recurring thought by some

participants if they decided to leave their abusive partners. Several participants believed that a stable job, more financial resources, and a strong personality were needed to live without their abusive partners. Some also thought it was important to live with their partners to preserve the family unity.

The sixth theme includes participants' thoughts that IPV should to be discussed and debated publically as an issue to find solutions rather than discussed within the boundaries of family and between partners. Participants suggested some solutions to IPV such as intense educational programmes for children in schools, empowering and educating women about their rights, and use of media to raise society awareness about IPV. Moreover, men should be educated about their duties and responsibilities towards their female partners and their children to ensure their stability and safety as functional families.

Table 7-1: Summary of the thesis findings

Study No.	Main findings
Study 1	Translation of CAS and adaptation of survey questionnaire: initial translation, expert panel's review, 2 focus groups discussions, back translation, and a final refined questionnaire was ready for survey
Study 2	Survey: Severe combined abuse is the commonest IPV type. IPV prevalence was low, compared to other populations. Severely combined IPV significantly positively associated with lower education level of both partners and participant's fear from their abusive partners. Emotional and/or harassment was only significantly associated with having ≥ 3 children. Lower score of all SF-36 items were significantly associated with severe combined IPV. Lower score of only emotional well-being item was significantly associated with emotional and/or harassment IPV.
Study 3	Qualitative interviews: six themes emerged: 1) Being abused: process and progression, 2) IPV Bio-psycho-social impacts, 3) Explaining IPV, understanding and beliefs, 4) Talking matters: silence, sharing, and safety, 5) Sustainability: tolerance, or leaving abusive partners, 6) Overcoming challenges. Women were silent, asked for help from God. Religion is used as an excuse for abuse by some men. Social values and culture predominated women's experiences and factors in influencing their decision to leave or stay with their abuser. Financial stability, relative marriage, and family support are factors protecting against IPV. Women believed that empowering women, education of future generations is the solution to IPV. Survey questionnaire did not reflect some types of IPV that Saudi women experienced

7.3 Translation of the CAS and adaptation of the survey questionnaire and accompanying documents

The translation of the CAS and refinement of the whole survey and the enclosed documents had to be obtained to ensure its acceptability to the survey participants. Apart from the general usefulness of the findings of the translation in preparation to the survey study, the importance of this study was underlined by the notable lack of studies in the area of Arabic translation in this specific context (IPV).
Translation, like any other type of linguistic process, is inherently non-linear in nature, with the potential for selecting various meanings being constantly managed through general contextual constraints [338]. Furthermore, translation is not a single process leading from a starting point ST= source text to a target point TT=target text, but a circular, basically recursive process comprising an indefinite number of feedback loops, in which it is possible and even advisable to return to earlier stages of the analysis [339]. In my thesis, I used different feedback loops. The expert panel 'discussion in the process of translation of the CAS questionnaire improved the quality of translation by their critical feedback when discussing the appropriate translated words with psychological, cultural, and religious sensitivity. The panel's feedback also had the strength of the synergistic effort between the bilingual members, especially when one of them had experience in dealing with violence (psychiatrist) complemented by a second lay person who had a broad understanding in the field of violence in similar (Sudan) socio-cultural communities to Saudi Arabia.

The process of adaptation of the survey questionnaire was informed by the translation theories discussed in chapter 3 and the International Test Commission (ITC) guidelines that were based mainly on the importance of the cultural aspect of translation [90]. ITC guidelines were developed because the technical literature for guiding the translation and adaptation process appeared to be incomplete at the time and scattered through a plethora of international journals, reports, and books and there was substantial evidence that current practices were far from ideal. One

of the guideline recommendations: (C.1: Effects of cultural differences that are not relevant or important to the main purpose of the study should be minimised as much as possible) recommended researchers to locate possible sources of method bias in the adaptation process of a scale. One approach to this was to assess the cultural distance between the source and target language and cultural groups. Assessment of cultural distance included considerations of differences in language, family structure, religion, lifestyle, and values [340]. I achieved this by selecting members of the focus groups who were familiar with the Arabic language culture and its diversity. Focus group's members were bilingual and well oriented in the Western culture, as two of them were born and lived here (UK) or in the US for a long time. Additionally, three had expertise in linguistics or psycholinguistics, which provided a valid contribution to the quality of the CAS translation and adaption of the survey questionnaire.

Guideline recommendation D.1 specified qualifications beyond knowledge of the two languages. Knowledge of the cultures, and at least general knowledge of the subject matter and its principles, was part of the selection criteria for the expert panel, the members of the focus groups, and the independent back translator. The use of these multiple methods (expert panel, focus groups, and back-translation) with participants experienced in linguistics and psychology fields ensured a high-quality translation of the CAS.

The D.2 Guideline recommendation pointed also to the importance of preserving both the linguistic as well as the connotative meaning in the translation of words. A good linguistic translation preserves meaning, but to preserve the connotative meaning, a target language word that preserves the "emotion" associated with the word is necessary. This was observed in question number 1 in the CAS "have you been in an intimate relationship?" Which implies the notion of being in an intimate relationship? However, in Arabic, the appropriate term was thought to be "Shareek" as pronounced in Arabic, which denotes both meanings of a husband and/or a partner, which is characteristic of an intimate relationship. The expert panel and focus groups attempted to use a proper Arabic word that preserved the meaning, and the emotion of the translated word was in the CAS questionnaire,

which increased the confidence that items would be understood by the questionnaire respondents and consistent with the original meaning of the items.

7.4 IPV and the ecological framework

In this section, I locate my findings in relation to literature and the different levels of the ecological framework: individual factors, micro-system, community, and society. The process of allocation to any one level rather than another has an arbitrary aspect can conceal its function at different levels and interrelationships between factors [341]. Although I discuss each of the ecological levels separately, one or more of the components of each level might work together in the dynamic process of IPV. For example, individual factors influencing the immediate partnership (micro-system), such as male dominance practice, might also be embedded in the macro-system in which the partners are based (Arabs/Muslim community). Hence, religion and culture will influence what individuals do in their relationships.

Previous research showed that IPV prevalence varied with socio-demographic factors: young women, having ≥ three children, less education of partners, lack of social support, being abused as a child or witnessing violence at home, and use of alcohol by perpetrators [342-344]. Previous studies conducted in Vietnam, Botswana, Mexico, and elsewhere, also found associations between economic and social disadvantage and higher risks of violence and crime in general and intimate partner violence in particular [345]. These associations as well were shaped by attitudes toward violence, which in turn were likely to be shaped by personal exposure to violence, the community-level structural factors that intensify such violence, and other correlates of socioeconomic status [346]. Markowitz and Felson found that persons of lower socio-economic status are more disputatious, they are more likely to express grievances, and are more willing to use physical violence to settle disputes [347]. It has been argued that adverse social conditions produce arousal, which, leads to expanded rules for assigning blame for retaliation, leading to a high frequency of violence [348].

7.4.1 Individual factors

Individual factors are ones that were related to the partners themselves such as their age, childhood, beliefs and religion, family size, personality, family, and their health status.

The mean age of abused Saudi women in my survey was 31 years. This was consistent with a pervious study (mean age=32 years) conducted among Saudi women attending primary health centres in Maddina (the second holy city of Saudi Arabia) [97]. This was also similar to other findings from a survey to measure IPV against Arab women in Egypt (mean age=30.7 years) [106, 281]. Other studies conducted among other cultures such as Americans, includes Hispanic people, and Bangladeshi found that most of the abused women were young (women in their teens and twenties) [349-352]. However, some studies showed that age has little association with IPV over the women lifetime [353-355]. Additionally, a previous study showed that younger women were more likely than older women to report IPV-related problems, if enquired about them in health settings [356]. It may be the willingness and hence the rate of reporting that may explain the high prevalence of IPV in younger age groups, as I found in the interview, that younger participants were more explicit and willing to discuss their IPV experiences compared to older participants.

In my survey, the results did not show any significant relation between IPV and the age of women. This contradicted the findings of some previous studies that showed that lifetime IPV decreased with age [357-360]. It also contradicted my expectation that older women would be living in longer, stable, and probably a fewer violent relationships. My thought of stability of older women in their relationships was based on my intuitive idea that a woman might live longer with a non-abusive partner, and the opposite could be true. In my view, this inconsistency between my survey and other surveys conducted in various countries discussed above might be explained by the differences in the socio-demographic structures and cultural practices in different societies such as gender discriminative practices, in particular male dominance. There might also be

differences in their beliefs regarding age of marriage, nature of intimate partnerships (legal marriage, civil partnerships), and what constituted IPV. During the interviews, some younger participants were explicit in their views about IPV and more active in their help-seeking behaviours, than older participants who expressed an attitude of acceptance to some male partners' behaviours (forced sex) and a silent response to this severe combined type of abuse, because of their beliefs in religion. This age difference attitude might reflect the social changes Saudi women going through nowadays in an effort to raise their voices against IPV. Additionally, for these young generations, it is a challenge to the underlying social and cultural norms that for centuries have condoned IPV.

In my survey, emotional IPV and/or harassment were significantly associated with having three children or more, but severe combined IPV was not. This is consistent with previous research findings that male perpetrators of IPV were more likely to report having fathered three or more children compared with those who reported no IPV during the last year [361]. Other studies showed also the association between IPV and rapid repeated pregnancies among abused women [362-363]. Another study among Cambodian women showed that women with more living children as well experienced more physical domestic violence [364]. The likelihood of violence (any type) in the past year was elevated if the woman had five or more children in Tanzania [365]. This association could be explained by the control of partner preventing women from taking contraceptive pills, or it could be due to the possibility that having three children or more create stress and more financial obligations and therefore, increase the risk of IPV:

> *Having many children establishes barriers to economic autonomy and creates the context for pronounced dependency and, ultimately, tolerance of violence. (pp.125) [365]*

In my interview study, the majority of participants expressed that loving their children and fear of losing them hindered them from leaving their abusive partners. Therefore, in the context of IPV, having children could trigger violence (if ≥ three children), as well as could be an obstacle to end such violence (fear of

losing children) [366]. In a study conducted in Australia, which examined the presence of children in abusive relationships and the roles they play in women's responses to the abusive experiences, researchers found that women's perception that their children had to witness IPV encouraged them to ask for help [367]. This showed that women had a protective attitude towards their children and that having children might influence their help-seeking decision. However, other factors could play a part. Findings from in-depth interviews with victims in southeast Queensland reveal the complexity of factors surrounding victims' help-seeking decisions when dependent children are involved, including service providers' inconsistent expectations and limited understanding of factors surrounding victims' responses to IPV [368]. Women who tried to protect their children from the harmful behaviour of their abusive partner through separation, on the other hand, often faced a lack of understanding and legal support. Similarly, my participants in the interview study expressed their fear of losing custody of their children if they decided to leave their abusive partners. It is important to align women' expectations, support services, and legal help to ensure that the needs of both the women, and their children are addressed when disclosing the abuse.

IPV cuts across all socioeconomic levels, however, researchers consistently suggested an association between low economic status and such violence. Stella proposed a theoretical model explaining this relationship shaped by social exchange theory about the impact of economic indicators on the risk of violence against women in intimate relationships [369]. The model predicts that violence would decrease when women's economic resources increase because, in gaining greater resources, women also gain more power. This might be explained by the fact that when women gain economic resources and become more economically independent, men might resort to violence to compensate for labour market difficulties they might face, and for frustrations when women outperform them [368].

My survey revealed a lower prevalence of physical violence compared to other Arabic and/or Muslim communities. One explanation for this might be the distinctive stability of the Saudi population that stemmed from the economic and political stability of the region where the participants have been brought up during their early life or inherited such characteristics generationally over time. Saudi population is probably stable economically since its foundation in 1932. My respondents in the survey were probably stable financially as the government granted them scholarships to continue their education, in addition to the family financial support, which most Saudi women could receive from their families. This is in comparison to the adjacent Arabic and Middle East countries that have similar socio-cultural and religious characteristics (Iraq, Iran, Lebanon, and Jordan), but unstable in their economic and political status, which brought up hardship in the life of their society members. This subsequently may result in a disturbed society that struggled in every aspect of their life, and may be violent, externalizing their suffering to harm their loved ones (women) or even themselves. However, my findings may not be generalisable to migrants from other Arabic and Middle East countries that have similar socio-cultural and religious characteristics. This notion of the role of political and economical status in the occurrence of IPV has been suggested by previous scholars that also recommended a paradigm shift include analyses of the structural circumstances of violence against women within a larger context of global economic stabilities [370]. The cycle between poverty, stress, and intimate partner violence is hard to break: poverty leads to stress; households have a fewer resources available to cope with stress, and stress is a source of violence:

> *Since poverty is inherently stressful, it has been argued that intimate partner violence may result from stress, and that poorer men have a fewer resources to reduce stresses (p.387) [370].*

During the interviews, the majority of my participants emphasized that having a stable job was influential in women's decision to leave their abusers and therefore, could break the cycle between economic hardship, stress, and IPV. This could be explained by the fact that if a woman has a stable job, she would be

probably independent financially and subsequently empowered, which might provide her with the courage and strength to decide to leave her abusive partner.

In this section, I will initially discuss the SF-36 scores of all the respondents (abused and non-abused). Although SF-36 scores of the non-abused respondents might not be related to the association of IPV, however, their health status needs to be compared with previous Saudi population norms and with other populations' norms. This subsequently ensured that the comparison of the health status of the abused participants with the non-abused is based on the appropriate norms of Saudi population. Then, I will discuss survey findings of the association between IPV and health status, illuminated by the informant' accounts of how IPV affected their health, and in line with the individual factors of the ecological framework.

In general, the mean score of several items of the SF-36 questionnaire (details in survey chapter) of my respondents were found to be lower than the mean of previously measured values in Saudi Arabia, US, and UK population based studies [230, 236, 371]. SF-36 scores have been reported to vary significantly between samples in different areas. This reflected the known variation in health status and mortality by region, even when controlling for social class, for example, SF-36 scores have been reported to be worse in West Glamorgan than in Oxford or Aberdeen, and higher in East Anglia and Oxford than in other regions [372-373]. Hence, normative data are essential to interpret SF-36 scores for any study population as the SF-36 User Manual recommends that norm-based scores (NBS) should be used rather than 0–100 scores to simplify interpretation of the data [374]. Another explanation to this lower score of SF-36 items might be due to questions order effects or contextual differences such as the nature of the survey (IPV) and the positioning of the SF-36 scale in the wider questionnaire (I followed ethics committee instruction in moving the mental items at the end of the SF-36 and before the CAS items).

There was a significant association between severe combined abuse and lower scores of all items of SF-36 health questionnaire, but only a lower score of the emotional well-being item was significantly associated with emotional IPV and/or harassment. Additionally, the CAS revealed that women with severe combined abuse had suffered significant fear from their abusive partners. Similarly, studies have suggested that type, proximity, and duration of abuse all affect functional health status.

Functional health status of abused women has been evaluated in a range of population studies and clinical settings in the US using the SF-36/12/20 questionnaire [14, 242, 375-379].These studies emphasised that the more severe was the IPV the more was the degree of negative health functions. In my survey, this association persisted after controlling for age, education, number of children, participants' fear of partners, length of marriage, and length of stay in the UK. The multi-variable model tested associations of IPV with factors at different levels in the ecological framework. This suggested that women exposed to IPV suffered negative bio-psycho-social outcomes, but the direction of such an association remained unclear because such adverse health outcomes might be predisposing factors for victimization or the consequence of it. A meta-analysis highlighted that the existing research is consistent with the hypothesis that intimate partner violence increases risk for mental health problems and that dose-response relationships of violence to depression, suicide, and post-traumatic stress disorder (PTSD) were observed [380]. This meta-analysis showed that the stronger the association between IPV and mental health problems, the more likely this association represents causation denoting that greater exposure to intimate partner violence is associated with larger risk of mental disorder.

Previous studies have shown that IPV-related morbidity and poor physical health compromise various functions, for example, the abused women' daily functioning, their quality of life, and ability to engage in their work, family, and relationship roles [381-383]. Intimate partner violence accounts for between 5 and 20% of healthy years of life lost in women aged 15-44 years [384]. However, SF-36 instrument is a self-reported one and does not provide definitive diagnostic

information about participants who might have underlying chronic medical conditions to explain their self-reported symptoms and signs. Asking participants in the interview of how IPV affected their physical, mental and social functioning informed the participants measured well-being using the SF-36 questionnaire. This was achieved, for example, by asking how IPV affected their health in general and whether they developed physical or mental problems due to IPV. Participants were also asked if they think that these problems were developed due to IPV. These sources of information combined (survey and interviews) about the association of IPV with the bio-psycho-social health status enriched the understanding of the abused women well-being. The majority of women I interviewed related their exposure to IPV to the development of signs and symptoms like chronic headache, migraine, anxiety, low mood, panic attacks, abdominal pain, nausea, and vomiting. My participants also expressed limitations in performing their daily life activities, fatigued, and lack of motivation to go out to socialise. They often felt isolated, especially in the first year of their residence in the UK. They emphasized the importance of their loss of freedom and control over their lives, exemplified by experiences of interference at work by their abusive partners and being physically restricted from contacting friends or relatives. Several of my participants also reported that the effect of IPV on the emotional and psychological well-being was more important and painful than the physical symptoms of direct physical violence. Similarly, a qualitative study using focus groups in the US showed that women with IPV expressed that their abusive experiences affected their physical and emotional health in four general categories: physical functioning, emotional and psychological functioning, social functioning, and their children's functioning [385]. Authors reported that the abuse manifested in physical terms beyond the injuries inflicted upon them, in symptoms such as headaches, insomnia, and fatigue, as well as psychological symptoms such as feelings of loneliness, isolation and depression. They also emphasized that while some of these conditions may have aetiology independent of the abuse, the women reported a self-perceived association between the violence and their physical symptoms. These bio-psycho-social problems were also quantitatively reported in previous studies findings, which showed that there

is a link between IPV and chronic diseases possibly mediated by patho-physiological responses to ongoing stress [332, 386]. Additionally, previous retrospective cohort studies showed that there was a link between violence, stress and somatic disorders, like chronic fatigue syndrome, and irritable bowel syndrome [332]. Other studies showed the same stress responses linked to various chronic diseases including, asthma, diabetes, and gastrointestinal disorders [387]. Similarly, several of my participants expressed some gastrointestinal symptoms of nausea, loss of appetite and abdominal pain.

In summary, consequences of IPV on women's lives are numerous and span their physical, psychological, and social well-being. IPV has immediate and long-term effects on women's health [388]. However, this association between IPV and adverse health outcomes opened the possibility that it could also be bidirectional. This means that violence could affect health in a covert or subtle way, or health could intersect with such violence leaving women with adverse health status vulnerable to abuse. The ecological framework suggested a non-linear pathway between IPV and postulated factors (including the individual health status); hence, it was difficult to predict the starting point of whether IPV leads to negative adverse health consequences or that adverse health status made abused women more vulnerable to IPV. In the survey study of my thesis, severe combined IPV was associated with a lower score of bio-psycho-social functions as measured by SF-36 questionnaire. However, my survey was cross-sectional and causality between IPV and health status was uncertain. My participants in the interviews who were exposed to various types of IPV expressed that they were very stressed and anxious and linked this to their exposure to such violence. However, in certain cases, adverse health problems might conversely lead to IPV, as in women with specific disabilities [389]. Similarly, I found from two women interviewed: one had a physical disability, and the other one defined herself as obese. Their disability and chronic health problem made them vulnerable to IPV in their view. Whether IPV could lead to adverse health outcomes or the adverse health conditions leads to IPV, the outcome in both situations would have an effect on

women, suggesting the need for tackling IPV and the associated related health problems.

With the aim of integrating underlying pathways between IPV and health, one study using eight focus groups of women exposed to IPV, showed a complex relationship with three main points of intersection between IPV and health: IPV leading to adverse health effects; IPV worsening already compromised health; and women's illness or disability increasing dependency on abusive partners [297]. This suggested that my participants who had disability and/or chronic health problems might make them vulnerable to IPV. Additionally, because of their disability, they might need additional support and help, which made them dependent on their abusive partners.

The use of the abuse scale (CAS) and SF-36 together in my survey helped me to form more sensitive modality for identifying more dangerous abuse situations, as I found mainly the severely combined abused women who had negative health functioning compared to less sever type of abuse (Emotional abuse and/or harassment). This means that severely abused women would be most likely to be at risk of developing bio-psycho-social adverse effects than women exposed to a lesser severe type of IPV. Similarly, a meta-analysis exploring the association of IPV with mental health problems showed a dose-response relationship denoting that the more severe the violence, the more would be the mental health problems [380]. Campbell also emphasised that women exposed to severe combined abuse puts these women at an even higher risk for health problems than women only physically assaulted [14]. Possible mechanisms of increased risk include the shame, and stress reported with, for example, forced sex manifesting as especially high levels of stress and depression known to depress the immune system [14]. Additionally, the qualitative interviews allowed me to explore wider aspects of self-perceived quality of life. Moreover, the qualitative reports of bio-psycho-social impacts of IPV by my participants in the interviews were consistent with their CAS scores, providing some internal consistency in my findings.

Other individual and socio-economic factors are associated with and blamed for IPV, for example: alcohol, smoking, and use of illicit drugs of both partners, which, were not addressed specifically in my thesis. However, some women in the interviews' study referred to these factors. These factors could have been included in the questionnaire to test their associations with IPV compared to other measured factors. Nevertheless, asking Saudi respondents about them would have been difficult and might even have decreased the response rate to the postal questionnaire. Additionally, drinking alcohol and use of illicit drugs are forbidden among Muslim and by Saudi law, therefore, asking about them would be an issue of high sensitivity and difficult to declare to a Saudi woman researcher who approached them via the Embassy (which represents Saudi government). Moreover, it might be difficult to trust respondents reporting for the same reasons.

7.4.2 Micro-system

The micro-system represents the immediate context in which abuse takes place, frequently the family or other intimate or acquaintance relationship [209]. It involved salient elements identified of the immediate social relationships (peers, partners, family) include the attitudes, beliefs, and subjective perceptions that each individual brings into the relationship and the dynamics within the relationship [214].

In Arab families, the man is considered the head of the family, and women's roles are largely restricted to that of housewives and mothers [390]. Many strands of feminists view IPV as arising from patriarchy, often defined as male domination over women in both the private and public domains and a cultural acceptance of women as subordinate to men [391]. This was evident in my interview study; the majority of my participants expressed that male gender dominance supported by familial, ideological, and structural patriarchy believed to be influential in facilitating IPV among Saudi women. Studies across cultures have reported strong associations between traditional attitudes toward women's roles and endorsement

of violence against women, such as wife beating, and between ambivalent sexism and attitudes condoning wife abuse [113, 392]. A further study among Arabs in Lebanon, which was based on the hypothesis that patriarchal attitudes are positively related to tolerance of wife beating revealed that individuals with traditional attitudes toward women's roles were more willing to endorse beliefs that condone wife beating [393].

Family norms might exert a strong influence in defining how a man is supposed to act, as well as the consequences when one deviates from this socially accepted gender role. Several of my participants expressed that Saudi males are brought up with the understanding that men are better than women are, and women should fulfil the desire of their partners even if women do not wish to do so such as forced sex. Additionally, women's acceptance of IPV and not responding to their partners' abuse is another influential factor in the dynamic of such violence. Several of my participants were silent and did not ask for help. However, they expressed several reasons for their silence, which included personal, familial, economic, and religious reasons. For example, fear of losing their children, fear of bringing shame to their families, financial constrain, and a sense of obligation to God's command to fulfil husbands' needs. This showed that IPV is a dynamic process that involved many factors at different levels of women's lives, which need to be considered pluralistically rather than singularly when investigating IPV [209]. This ensured the appropriateness of selecting the ecological framework to inform my thesis synthesis and the explanation of my findings.

Findings from the survey revealed that there was no association between the prevalence of IPV and the length of the partnership. This was consistent with a previous study in a similar socio-cultural context (Islamic Republic of Iran) to Saudi Arabia [394]. However, population studies in Cambodia and Greece showed that the duration of relationship was inversely related to violence against women [159, 364, 395]. Another study in USA found that a higher rate of violence among couples in shorter relationships [396]. The absence of association

in my survey could be explained by the sample size, as the CI was wide, with insufficient power to detect an association compared to these studies that reported such an association using larger samples. Nonetheless, findings from the interviews, when women were asked why they stayed with their partners, although violent, revealed some age differences in my participants' response to this question. Younger participants were more confrontational and argued with their abusive partners expressing their rejection to such violence. Nevertheless, several of older participants were more tolerant and coped silently with their abusive partners. Some women resigned to their fate due to social and cultural norms.

The majority of participants, who were in long partnerships, coped through praying and forgiveness, and for some, it was the hope that violent partners might change. It was perhaps this which could lead to reinforcing the husbands continuing violence. These women's responses could be thought of as a positive reinforcement for a continuous pattern of abuse, along the lengthy partnership type, and supported by these women's attitudes. Another possible explanation could be that exposure to a violence continuum leads to the normalization of such behaviour and changes the way individuals perceive themselves, their relationship and IPV over a long period [397]. Steele and McGarvey found that American Samoan women had more difficulty with controlling anger than traditional Western Samoan women [397]. These authors thought that American Samoan women were exposed to a more individualized way of life with associated increases in the number of situations of interpersonal conflict. They may respond to these situations with more diverse coping skills to contend with their changing lifestyle [398]. However, expression of anger and objection to abuse by some women should be considered an active response to such violence and might influence men's attitude and prevent further IPV. My participants' response of praying and forgiveness of their partners might be explained by their coping skills to contend with their new lives in the UK. Some of my informants expressed that life in the UK, in particular, mixed education between men and women, created situations of partners' conflicts and explained how they coped with this by

praying and accepting their partners' abusive behaviours. This tolerance and coping strategies subsequently might lead to the continuity of abuse along the lengthy partnership.

Many of my participants also expressed that they had difficulty at the start of their marriage relationships because, as couples, they never knew each other before (arranged marriage), and it took them many years to adapt to the new relationships. While couples, who were cousins found it much easier to live in harmony because they knew each other since their childhood, in addition to the protective environment provided due to the obligation of respecting the same family honour.

While physical violence was low in my survey results, the severe combined abuse was high, which might reflect the rigid cultural gender role and other selective mis-interpretations of religious instructions, which I will discuss in the next section.

Previous studies in the US and Korea have reported an association between violence-supportive beliefs and values, and the perpetration of violent behaviours at both individual and community levels [300, 399]. Beliefs and perception about IPV might involve understandings of what constitutes violence, and/or what the abused women believe to be causing IPV. In this section, I link the findings of the prevalence of IPV to participants' beliefs and perceptions about IPV in terms of its definitions and aetiology as expressed in the interviews.

The majority of my informants tended to normalize some of the types of IPV such as emotional abuse. They defined it as temporary, reasonable, manageable couple conflicts in order to reconcile these acts by adhering to values of commitments and self-sacrifice in the relationship and by using strategies to survive. Several participants, that were classified as emotionally abused by the CAS, did not perceive that they were actually abused. And they justified it as normal couple conflicts that occurred from time to time and 'nothing serious' and not an ongoing pattern of aggression. Similarly, a qualitative study among Iranian women

revealed that they expressed acceptance beliefs about psychological violence such as frequently bullying [400]. Follingstad emphasized the point that contextual factors should be considered such as: women perception of whether the act is normal or aggressive [401]. That is why some researchers have even recommended that a negative outcome, such as expression of anxiety or insomnia by the abused women, is required as part of the definition of psychological abuse rather than the act of abuse alone [402]. The CAS does not measure consequences of IPV (apart from fear of abusive partners). Moreover, it is difficult to assess the extent and perceptions of negative outcomes as individuals differ in their threshold and sensitivity for harm, beliefs and attitudes about their intimate relationships or personality traits, which might influence the interpretation of the intentions of the partner.

My finding of a lower prevalence of physical violence than other types does not match other studies, which demonstrated that physical violence is the most common form of violence among Muslim women [101, 403-404]. This might be due to the differences in the instruments used in these studies (often variations of the Conflict Tactic Scale), which might have a limited range of violent acts that respondents were asked about and might not give sufficient information about the pattern and severity of IPV. Another study showed also a higher prevalence of physical abuse among Palestinian women in a household survey that was found to be 23% compared to 2% in my survey [405]. This difference might, furthermore, be explained by the instability of the socio-economic status of Palestinian women and the stress of living under occupation compared to Saudi women who are relatively stable politically and economically. However, this might be low reporting by my participants, which, could be explained by some factors explored during the interviews such as the stigma of reporting, fear from the societal negative perception of being labelled as abused, and the different perceptions of what constitute abuse. Although reporting was anonymous, some women, who did not take part in my survey, might still are concerned about the negative societal perceptions. Therefore, my survey might miss such a group of women and hence resulted in a lower prevalence of physical IPV. Moreover, the low prevalence of

physical abuse might be because my sample was in the UK. In the UK, strict legal rules are in place hindering some men from committing such violence compared to the legal system in Saudi Arabia where there is lack of legislations regarding IPV against women.

The finding of the interviews might illuminate the finding from the survey of a lower physical abuse prevalence, as the majority of women avoided disclosure or remained silent, because of fear of losing their children or retaliation by their partners. This might be an indicator of the wider Saudi societal view of reluctance to disclose physical violence. However, disclosure by women who completed my survey and whom I interviewed, was triggered by wanting someone to listen and to explain the partners' behaviours rather than asking for help. Additionally, findings from the interviews might be transferable to some Saudi women but could not be generalized in a statistical sense. Some suggested that there is a lower prevalence of IPV among religious communities where moral religious values could have a protective effect on families [406-407]. Another principal should be considered here is that there is a difference between lower reporting of physical abuse and lower prevalence of such violence. If women perceived such acts as violence/abuse, such as wife beating in some Islamic countries that is not considered abuse, and determined to declare it, then the measured prevalence would be higher. This argument also applies to the emotional abuse data that is even less defined and varies in different socio-cultural contexts. In the interviews, informants tended not to label some acts of emotional abuse as abuse. Wagner and Mongan provided some evidence of discordance between a participant's perception of abuse and a standardized measure of abuse and emphasised that the participant agreement that the behaviours were abusive varied among the different scenarios among both those women who reported abuse and those who reported no abuse [379]. This suggested that what some researchers document as abuse might not be considered abuse by respondents.

My survey revealed that severe combined abuse was the most prevalent type of IPV among my participants. Interviews supported this finding when the majority

of my participants expressed that IPV is all about control (main theme of severe combined abuse) by their abusive partners such as preventing them from going outside home or work. This concordance between the survey and interview findings increased the confidence and trustworthiness of such findings and enhanced the understanding of the nature and extent of IPV. The finding that severe combined IPV (reflecting control and dominance by male partners) might be explained by the inherited cultural and politico-legal controlling practices Saudi women exposed to at the societal level that I will explain in the following section.

In line with the beliefs theme expressed by the abused participants was the common perception expressed during the interviews that the husband's childhood could influence their pattern of behaviour with his wife. This belief was expressed by some of younger participants who were university graduates and less tolerant of their abusive partners. This might suggest their awareness and knowledge of the dynamics involved in the intimate partnership, and this subsequently empowered them to face such violence. Social learning theory suggested that children may learn aggression from their parents and sometimes re-practice this behaviour in their adulthood relationships [408]. The expressed link, between a partner' childhood experience of abuse and later adulthood aggressiveness towards women, might be related to the possibility that violence against women could be related to a mechanism called intergenerational transmission, in which the violent social relations of the society were passed on from generation to generation, although this evidence is contested. Longitudinal studies also documented the intergenerational transmission of violence-supportive attitudes and behaviours [409-410]. There was evidence that children who either witnessed such violence or were subjected to violence themselves were more likely as adults to adhere to violence-supportive attitudes and to perpetrate violence [411].

Beliefs surrounding IPV differed in various cultures and might enhance existing gender inequalities in these societies such as male-dominance practices. Such beliefs might also influence reporting of different violent acts and hence might

explain the differences of the prevalence figures. However, other methodological issues could play a role in explaining the different prevalence rates within the same community and/or other communities, which I will discuss in details in the following section.

7.4.3 Community (Exo-system)

The exo-system refers to:*"the social structures both formal and informal that impinge on the immediate settings in which a person is found and thereby influence, delimit or determine what goes on there"(p.321)[213]*. Exo-system involved many issues related to the community they lived with such as: the education level of both partners, and isolation from family. Heise suggested that a significant observation about exo-system influences is that they are often the by-products of changes taken place in the larger societal milieu such as social isolation stemming from increased migration in the population [209]. I will discuss these issues in the below section.

Previous studies showed a high frequency rate of IPV among immigrant women, and they explained this by their social isolation and vulnerability highlighting the role of immigration status on women's vulnerability to partners' abuse [412-414]. A study of domestic violence in Mexican-origin families in the U.S.A found that families with abusive men were characterized by immigration-induced role changes that caused men's loss of family and social status [415]. This observed relationship between immigration status and women' exposure to IPV could be influenced by the length of stay in the foreign country indicating that the longer they stayed in, the less the frequency of violence due to the gradual adaptation to the changing environment [416]. Furthermore, studies have shown that attitudes towards violence against women by men can improve with Western acculturation [417-418]. In my survey, I did not find an association between length of stay and exposure to IPV. In the interviews, the majority of informants believed that the longer they stayed in the UK the fewer conflicts with their partners and subsequently, the less violence they experienced. These women mentioned that

being in the UK helped mutual understanding with their partners, and that they had more time to be together than in Saudi where interference from extended families was reported. This subjective positive experience of being in the UK (immigration) might be explained by the fact that the couples away from the obligations of the family and culture provided a peaceful time for them to be close together. Time and place are important constructs that affect culture and its interpretation [419]. Hence, researchers investigating IPV in communities living outside their homeland should consider the role of time and place of residence in triggering such violence.

By way of contrast, lack of social support from family and friends was mentioned by some of my participants to be a factor influencing their exposure to IPV and may negatively accentuate its effects. This is consistent with previous studies showing that absence of-or poor social support was associated with greater exposure of women to violence from their partners [420-421]. However, these studies were conducted in primary care settings and could provide different results if the study were conducted in the general population. Studies conducted in primary care would be relatively biased because individuals recruited from such settings were most probably sick and were asking for help with various symptoms and signs. While population-based studies would be more reliable because of the absence of selection bias as everyone would have an equal chance to be recruited if appropriate sampling was applied.

Caetano and colleagues suggested another explanation of the association between immigration status and exposure to IPV that the difficulties associated with negotiating between two cultures might contribute to partner violence. They thought that the potential lack of ties with the culture of the homeland, and with that of the adopted country might lead to increased stress, conflict, and partner violence [422]. A few of my participants expressed similar view when they arrived at the UK where they faced some difficulties in understanding the society, challenge with the English language, and the open culture environment compared to Saudi, which is conservative. Similarly, Duituturga pointed out that Pacific women living in New Zealand face specific challenges with conflicting

expectations about their partner and familial roles, often leading to tension and possible violence [423]. Some of my participants expressed that their male partners had forgotten about their role as a responsible husband and father to their children, and this had lead to a conflict, tension and subsequently to violence.

Another important socio-demographic factor in IPV dynamic was educational level of partners. Interview data suggested that IPV occurred in a context of a relatively wide gap in the education level between the husband and wife in some interviews, particularly when women were more highly educated than their partners. A previous study in Muslim country (Albania) found that women were at higher risk if they were more educated than their husbands were [424]. However, in the survey part of my thesis, couple education was significantly associated negatively with severe combined IPV, findings that are consistent with the literature, so that the less the education attainment the more was the risk to IPV, but not with emotional and/or harassment abuse. Previous studies reported that partners' level of education has been reported to play a role in the prevalence of IPV negatively or positively. A study reported that the rate of IPV was higher among women with less education [425]. Furthermore, among Syrian women (Arabic and Muslim), a study found that lower education of women was correlated negatively with IPV [426]. This was explained by the fact that higher education could suggest higher income, improved self-confidence, and access to social networks and information resources to protect women [241]. In a review article, high educational status of women was associated with low levels of violence in some countries, whereas in others the relation followed an inverted U-shape pattern, with low violence rates at the lowest and highest educational levels [427]. This finding suggested that empowerment (including education) and IPV is related in a curvilinear manner. Greater empowerment reduces the risk of exposure to IPV up to a point, beyond which the risk increases before levelling off as empowerment becomes protective [341]. This means that having some education empowers women enough to challenge certain aspects of traditional sex roles, but that such empowerment carries an increased risk of violence until a high

enough level is reached for protective effects to predominate. Thus, during periods of transition in gender relations women may be at increased risk of violence [427].

7.4.4 Society (Macro-system)

The macro-system involved issues related to society such as law, legislations, resources available to abused women, culture, religion, and society gender role. The macro-system refers to the broad set of cultural values and beliefs that permeate and inform the other three layers of the ecological framework (individual, micros-system, and community layers) that discussed above [209]. Most feminist discourse and theorizing on violence against women have included a focus on macro-system factors such as patriarchy, as well as micro-system factors related to abusers [209].

The findings of the interview study suggested cultural variations in understandings of IPV. Participants who were classified as emotionally abused by CAS perceived, some actions that are unique to Arabic and Islamic cultures (legally preventing women from study or travel, for example) and control by partners in many aspects of women's live as more damaging type of abuse than physical IPV. These participants reasoned that the controlling acts restricted their autonomy, which deprived them of socialising and satisfying their self-esteem needs and decreased their self-confidence. Control made them isolated, and this was compounded by the effects of abuse on women's mental state, which might then lead to an increased risk of violence [34]. This variation of perceptions of IPV suggested that these definitions (particularly emotional), by the CAS or other validated instruments, might not be universal when applied in different cultures. This difference in definition of IPV observed particularly when I struggled during the interviews with some women who were selected based on their CAS score but when interviewed, did not perceive that they were exposed to violence, and some denied it. The ideas these women expressed during the interviews suggested also that they might not be abused, as they perceive such acts as normal behaviour in a

marriage, which occurred occasionally but never represented a systematic exposure to violence.

This cultural variation in defining IPV suggested development of measures contextualized to different cultures or modification of the existing tools. Improbably, in some cultures, IPV terms do not exist and are not readily translatable [29]. For example: marital rape in English speaking communities is well recognized and unacceptable, while in Arab and Muslim communities, no such term exists and forcing a woman to have sex by her partner is not a rape but rather an obligation to fulfil the husband's command. In the CAS, there are two items specifying rape and attempted rape; several informants perceived these acts differently during the interviews. Therefore, participants who believed that marital rape is not a rape might answer no to such questions. In some Arabic countries and as a religious practice (in Islam), women are obliged to fulfil the husband's sexual desires, even if they do not want to. A study has reported a positive correlation between traditional sex-role perceptions and attitudes endorsing the legitimacy of such violence [428]. This type of act is defined as sexual violence by the Centre for Disease Control and Prevention (CDC) [429]. In Islam, there is not to be causing of harm, nor reciprocation of harm, hence, in my view, for a man to force himself upon his wife leads to severe harm.

The majority of Saudi women interviewed believed that having sex without their consent was un-acceptable behaviour. The same view was expressed in a previous study conducted among Arab Muslim women identifying their right to refuse sex if they were tired or not in the mood [430]. This difference in view about marital rape might be explained by the age difference as I found that older participants still held the old belief that a woman should be obedient to her husband' desires, while the younger participants did not accept such an act and considered it rape. This might reflect the enhanced empowerment of Saudi women during the last a few years and increased awareness of Saudi population about IPV (personal view). However, some older might find it difficult to acknowledge that they have been raped by their husbands. This is could be explained by not only the fact that the concept of marital rape is not articulated in Islam, but also because they may

have accepted it for so long, that to acknowledge it now would undermine their identity. Subsequently, this might influence women's bio-psycho-social well being and a continuous pattern of unreported sexual abuse.

One of the recently acknowledged factors predicting IPV was cultural attitudes women held towards IPV, indicating that women who were holding tolerant attitudes towards IPV (In Iran, Babel city) were more exposed to a higher degree of violence than intolerant women and exceeding the contribution of possible other socio-demographics [431]. This study showed that the strongest predictor for physical abuse was women's attitudes to acceptance of male dominance. The research showed that violence in the home boundaries has generally been perceived in terms of a high level of acceptance from the family and the victims [432]. Another study also suggested that the root of substantial differences in the prevalence of violence in various societies was related to cultural differences in the status of women or acceptability of interpersonal violence [395].

In an English speaking culture, Johnson and Sigler pointed out, in a population-based study conducted among the general public of Alabama to assess attitudes and perceptions about IPV, that people have a relatively low level of acceptance of interpersonal violence and that this low acceptance pattern seems to be stable over time [433]. I found my participants in the interview study, compared to other women such as the women in the US in the above study, varied in the way they viewed the same violent behaviour of their partners with respect to its aggressive qualities. For example: some Saudi women did not consider some emotionally abusive acts as abusive such as shouting aggressively. Jewkes suggested that wives who respect cultural norms would be unlikely to challenge the patriarchal norms within the family and would try to avoid conflicts with their husbands [427]. Similarly, some of my participants accepted forced sex based on their respect for the notion that it is a curse if the woman did not accept such behaviour. However, the majority of my participants highlighted the point that nothing was wrong with religion itself, but only in how it had strayed from its original intent. Understanding the role of religion in participants' lives would help in explaining their help-seeking behaviours and coping. My participants addressed the issue that

it is culture, which imposed these false interpretative meanings of the role of men and the use of power to control women. Therefore, they suggested that if we change these cultural values and believed that religion is free from these false claims, women would not suffer IPV. This is in line with what Coleman explained about Islamic feminism that fights for progress in cultural change while respecting religious faith [434]. Muslim feminism is the search for that elusive middle ground between the demands of religion and the needs of modernity. She also emphasised the importance of colliding with what she called the twin powers of culture and religion in advancement of women' empowerment. In other words, fighting theology with theology becomes a tactical necessity. My participants emphasised that understanding the true message of the religion with regard to women would solve the problem of IPV; hence, they used their understanding and interpretations of the Islam (theology) to fight male-made false interpretations of their role with regard to their partnership with women.

When violence experiences associated with these diverse backgrounds give rise to different normative standards for judging behaviours, it is not uncommon for activities promoted as suitable forms of conduct by some individuals to be considered antisocially aggressive by people who adhere to different codes as in Western communities. For example, in Sri Lanka, a South Asian country, with a unique culture that has been shaped by Buddhist teaching, women were more likely to experience continuously and current isolated psychological abuse by husbands if they did not believe that "a good wife always obeys her husband" [435]. When Agbayani-Siewert explored perspectives of IPV in Chinese, Filipino, Hispanic, and non-Hispanic White college students, post hoc analyses revealed that the group of Chinese's students scored significantly higher on justification of abusive behaviour than all other groups [436]. This could be explained by the point that some participants might read the wording of the questions leading them to feel that the questions did not apply to them; hence, this influenced their response to the survey items or might not respond to the question. Waltermaurer and colleagues pointed to what they called a relevant construct validity consideration in measuring IPV that is the level of correlation between reported

counts of violent acts, as proxies for severity, and victims' actual perception of the severity of the violence, as these two measures are often dissimilar [98]. Unfortunately, some people "perceived" words differently, such as marital rape, and still more would not discuss their experiences until a certain level of trust had been developed with the interviewer. For example, rape and having sex without consent as an Islamic command would probably be less reliable to explore in the survey only by using one-question "have you ever been raped by your partner?" Asking about whether having sex without a woman's consent is acceptable or not might be embarrassing to some Muslims, who still believe that having sex without consent for women is a God command, and they are obliged to follow. However, during the interview, I managed to approach this issue sensitively with my participants.

Therefore, cultural, societal perceptions, and attitudes determined what constitute violence. This has been explained by the suggestion that there are associations between cultures and attitudes towards violence that seemed to be dynamic. There is evidence that people who move from a more violent-supportive cultural context to a less violent-supportive one could have their tolerance for violence lessened as a result, and their attitudes changed with Western acculturation [417]. This is consistent with what some of my informants expressed in that their partners became different by being in the UK and less aggressive because, as the women summarised, they were more controlled by the UK legislations against women's violence.

In summary, the interpretation of the survey results using CAS became more problematic through the interviews. The variation and specific Saudi cultural context (not allowing women to travel without male written permission) became clearer after analysing the interviews' data. Data from the interviews provided the dynamic and interactional perspectives (individual, familial, societal, and legal). This means that IPV involves influential and continuous interactions between partners and the various situations they encounter.

The political structure of Saudi Arabia has a strong impact on women's position in Saudi society. In Saudi Arabia, political decisions have been the main decisive factor in regard to issues related to women [437]. The Saudi kingdom's Basic Law of Governance elevates the Qur'an and the Prophet's traditions (Sunna) to the status of a constitution. Consequently, the religious establishment plays a central role in the country's governance and has broad influence over many aspects of everyday life [438]. For example, the Permanent Council for Scientific Research and Legal Opinions (CRLO), the official institution in Saudi Arabia entrusted with issuing Islamic legal opinions, when asked about women's employment, said:

> *God Almighty ... commended women to remain in their homes. Their presence in the public is the main contributing factor to the spread of fitna [strife]. Yes, the Shari'ah permits women to leave their home only when necessary, if they wear hijab (head scarf) and avoid all suspicious situations. However, the general rule is that they should remain at home (pp.288) [439]*

Cultural customs that deny women equality have become entrenched in some Muslim culture to the point where they are often accepted as Islamic rules [440]. During the interviews, several Saudi women living in the UK believed, as noted above, that they were more protected by the UK systematic regulations and rules preventing their partners from being violent towards these women. These informants were comparing the UK (with clear law related to IPV) with their homeland, Saudi (with less, and may be absent, clear legislations), leaving women under the mercy of a few moral social values and religious beliefs. Women in Saudi Arabia are living under ideological choices made by some men who can choose to apply, or not, the expected moral, social and religious values regarding the intimate relationships between couples, combined with the Saudi governmental legislations, which tend to operate together with these men against women [313]. Radhika Coomaraswamy pointed out to what she called "man-made" practices performed by the name of religion, and this is similar to the notions, which some of the informants expressed during the interviews:

> *Though interpretations may vary, there is no question that all the world's religions are committed to the pursuit of equality and human rights. However, certain man-made practices performed in the name of religion not only denigrate individual religions but violate internationally accepted norms of human rights, including women's rights. (pp.66) [313]*

However, the Saudi government' efforts and measures in restoring women's rights with regard to their lives and well-being is still at an early stage. There is little evidence that these measures are actually implemented in practice [283]. Human Rights Watch pointed out the importance of the Saudi government taking action to end discrimination to women:

> *Saudi Arabia's accession to the United Nations Convention on the Elimination of all Forms of Discrimination against Women in 2001, however, obliges Saudi Arabia to take action to end discrimination against women without delay. For as long as it fails to take steps to eliminate the discriminatory practices of male guardianship and sex segregation, the Saudi government is scorning its international commitment to guarantee women and girls their rights to education, employment, freedom of movement, marriage with their free and full consent, and their right to health, including protection from and redress for family violence. (p.4) [283]*

As Lipsky pointed out, there is often a demonstrable gap between the "law on the books" and the implementation of "law on the ground." Lipsky considers the disconnect that occurs between policy directives and pragmatic implementations of public policy as an inherent condition of bureaucracies [441].

In the interview study, given the variability of women's views about the culture, religion, and economic-political issues in terms of their exposure to IPV, it is difficult to predict the degree of change and progress in Saudi society, in particular, those who still adhere to old traditions, which resist any forward social change. Some participants expressed some of these old traditions, for example: men are better than women are, and they should obey husband's commands. However, some of the younger participants expressed different strong views, which might reflect some changes in the new generations of Saudi women as discussed above.

At the macro-level, recent political changes and revolutions in Arab nations in the Middle East are signs of human voicing, as well as the signs of slow but steady

changes occurring in Saudi Arabia regarding women's rights. Until these changes take root, women's issue would be at the centre of conflict between cultural traditions and the political future of Saudi Arabia.

At an international level, the efforts of feminists who have worked with abused women and demanded changes by law enforcements were successful examples reflecting the involvement of political activity with IPV [442]. Whether with regard to identity or political reforms, gender is one of the major issues to be addressed by the world community. It is also one of the most crucial issues facing Muslim' women in modernity:

> *The failure to include women in the macro-economic policies as major and potential actors leads to the exclusion of half the human resources and their potential from the national development process. Therefore, mainstreaming women in the whole policy process is not only a matter of social justice, but it is an economic imperative. (p.157)[443]*

The political status of Saudi Arabia is controlled by religion (Islam), and as religion and its role in defining intimate partner's relationships were recurrent thoughts among my participants, politics and religion combined might intersect in the process of IPV. My participants were often silenced by the threat of further violence, and by the cultural support of the idea that the domestic domain is the private realm of male dominance where women must obey. Such a disadvantage results from the split between personal Islamic identity and forces of institutional and political Islamic policy. Without comprehensive (female-inclusive) Islamic moral policies, Muslim women are continuously exposed to abuse but forced to comply by circumstances that justify their silence [444]. Many of my participants emphasised that these Islamic polices (restricting every aspect of Saudi women' life) resulted from mis-interpretations by some men of Islam, and supported by Saudi governmental legislations. My participants' knowledge of their Islamic rights and their understandings and interpretations of their intimate partnership, highlighted the importance of their role in reforming these Islamic political patriarchal practices. This reforming of Islam was explained further by Mir-Hosseinin, who emphasised that gender rights in Islam are neither fixed, nor given. They are not absolute, but they are, on the contrary, cultural and legal constructs, which are asserted, negotiated and subject to change [445].

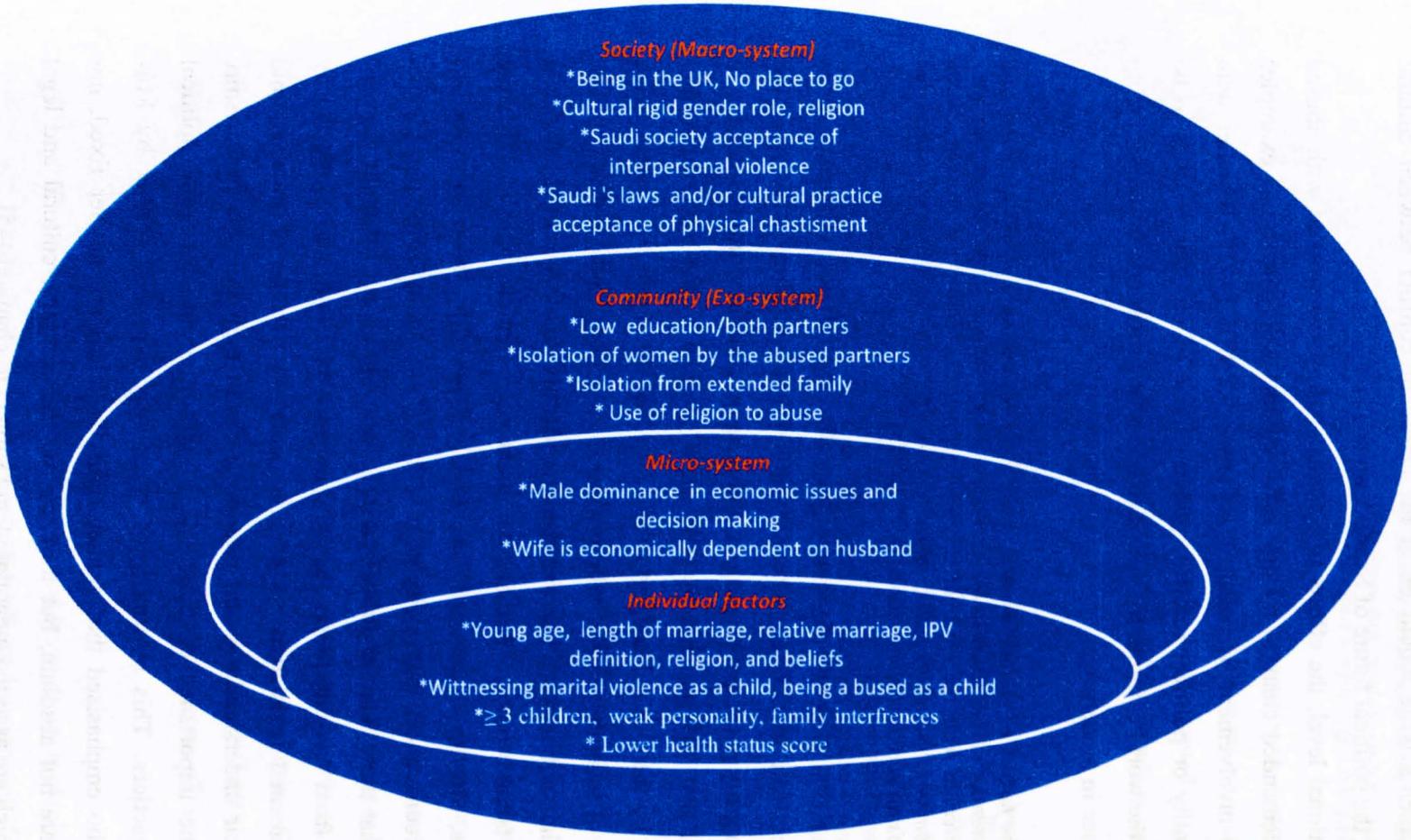

Figure 7-1: ecological framework linked with thesis results

7.1 IPV types and participants' help-seeking and coping

This section explained participants' help-seeking behaviours and coping after their exposure to different types of IPV. The survey measured the prevalence of various types of IPV, but did not ask about women's response to such violence. Behaviours of abused women in response to IPV were, specifically, explored during the interview section of my thesis. Therefore, data interview findings were the only data on participants' response to IPV.

During the interviews, participants related their help-seeking behaviours to the types and severity of violence they had experienced. Similarly, previous researchers reported that, as violence became more severe, women were more likely to seek assistance from service resources [319, 446-447]. This suggested that these women with severe combined abuse fear for their personal safety and hence asked for help to protect themselves. The majority ranked the police and/or public help resources (such as Women's Aid in the UK) as the least likely bodies they would approach for help. Only one informant asked for police help because her husband raped her. This finding was in line with other studies, which pointed out that in dealing with abuse, immigrant women may be reluctant to engage with the police or other criminal-justice services [448-450]. It has been explained by the idea that police involvement might expose women's immigration status or invite further scrutiny by child welfare officials [451]. However, my informants expressed different reasons for not involving the police because such actions were inappropriate and denoted lack of respect to the husband in their views. This perspective might suggest the powerful influences of cultural and social values on some women's decision on how to respond to IPV. These different perceptions regarding the severity and type of IPV, in addition to the consideration of cultural value, could partially explain their reluctance to seek help.

Response to IPV depended on both the women's reaction and community, and institutional response to such violence. Most of the informants preferred not to ask for help immediately after their exposure to any type of IPV, while some were not sure where to go for help in any case. Those women who did not ask for help, expressed many reasons such as fear of retaliation from the partner, hope that their partners will change, emotional abuse being perceived as not serious, not wanting others to perceive their partners negatively, and concern over self-pride and fear of losing their reputation in the society. This is in line with what Liang and colleagues suggested in terms of culture influencing women's decision to seek help and from whom they asked for such assistance [452]. Other factors, researchers reported, included various barriers to help-seeking such as values emphasizing women's submissiveness, placing the needs of family before one's own, and stigma regarding divorce [452]. Additional, ethnic differences in help-seeking have been found. For instance, Latinos who adhere to traditional values were found to be less likely to discuss their abuse with non-family members for fear of bringing shame to their family, and were less likely to seek help from friends and family than White women in the US [453]. This has been attributed to the effect of acculturation that reflected women's adaption process to the new culture where they reside, and was similar for my participants who expressed some difficulties in adapting to the life in the UK in the initial period of their residence. This reluctance to ask for help could also be explained by the fact that, despite the economic and social advancement they have reached, women in Saudi society might still live their lives according to the deeply rooted patriarchal and patrilineal extended family values. This implied that a woman belongs to the father patriline even after her marriage because she carries his name and remains accountable to the family honour, particularly, among the tribal families. This barrier to help seeking was explored in a recent study conducted among Arab immigrants to explore the barriers among women who were in partner abusive relationships. The study showed that there are multiple individual, cultural, religious, and societal factors which influenced the decision of these women to ask for help, among which was the fear to break the family ties and bringing shame to their families [454]. Similarly, immigrant Mexican women, South Asian,

and Vietnamese American women have expressed that culture, and ethnic norms might interfere in the way women views and approach help resources [305, 321, 448].

A few of my participants asked for help, but after a period of time from the violent events. Those women who asked for help; their main reason was not to have any intervention but to find explanations for the partners' behaviours or to express their suffering to a family member, a friend, or a health professional. Some informants sought help but never outside the family boundaries. Some talked to the father, sister, or brother for support and, sometimes, to confront the husband who usually bears special respect, particularly, if a woman was married to one of their relatives as cousins. The usual intervention in couples' problems, among Arabs and Muslim communities, by respected kin, valued other family members, or religious figures, might not exist in the UK for the informants, making it difficult to seek help. This suggested that immigrant abused women might end up with a sense of social isolation, in particular, from their family. Therefore, Saudi women lacked such support and resources in the UK, and this contributed to the majority being silent about their abuse experiences.

Economic and emotional dependency could also impede a woman's ability to terminate an abusive relationship [315]. Hence, women who were financially dependent might be more likely to tolerate abuse. During the interviews, several Saudi women addressed the importance of economic stability and having a job as important determinants aiding women to leave their violent partners, so they could afford to live independently.

Findings from the interviews highlighted several factors at various levels (individual, familial, and social levels), which were in line with the ecological framework components, influencing Saudi women's response to IPV. Contextual factors have been highlighted by some feminist theorists who focus on the importance of context as both an epistemological and methodological issue. These factors *"frequently supports the status quo and potentially defends oppressive conditions" (p.323) [168]*. These factors also represented challenges to the

methods for re-conceptualization and operationalizing contextual factors salient to the measurement of IPV. I will discuss these methodological challenges in the following section.

7.2 Methodological considerations

7.2.1 IPV reporting

IPV is a sensitive matter, and underreporting is a universal phenomenon [455]. Furthermore, the fact that the principal researcher was Saudi and somewhat known to some respondents could have restrained these women from disclosing their IPV when posted the survey, because they might feel ashamed by being labelled as abused women and might be due to fear of retaliation from their partners. However, certain precautions were taken during the survey to improve this by ensuring the participants in the information sheet that their answers would be anonymous, and provided with information about help resources available for them in the UK. I hoped that this relative familiarity between my participants and myself (coming from the same culture) rather contributed to feelings of trust and confidence. The rationale behind this explanation is that the majority of women interviewed appreciated being asked about this problem, and some actually expressed their appreciation by writing such feelings at the end of the self-reported questionnaire. Using CAS as a dedicated specific tool to IPV might help in reducing underreporting. Dedicated IPV tools, rather than general violence tools, tend to yield higher disclosure of violence because they included specific acts within a specific context (intimate relationship) [456-457].

The results could be influenced by the fact that all survey data were based on self-reports and therefore, might be inflated or deflated. At the time of completion of the survey, participants might have been suffering some sort of mental or physical problems leading to a general negative attitude and hence, may have rated their health or IPV exposure as more serious or more often occurring than women who were not. However, according to Saudi women traditions of not telling outsiders about their abuse and the belief of the necessity of keeping silent, the phenomenon of over-reporting was not probably a problem among my study population.

Mooney pointed out that: *'although the questionnaire [about IPV] schedules appear objective; they display the subjective values of the social scientist and are differently interpreted by respondents'(p.124)[458]*. Hence, my participants might have different meanings of some of the acts included in the CAS, such as rape by the partner. Some women, who believed in the notion of complete obedience of women to their partners' wants and needs, might not see such an act as rape. This belief might lead a woman to either ignore this question as she thought that it is not applicable to her situation, and/or might answer no, and in both situations, underreporting is the resulted outcome in the survey. This could be avoided by using forced sex rather than rape as it might be perceived lightly by respondents with a lesser criminality element that is more obvious in the term rape in general. Jewkes and Abrahams point out that:

> *a given incident of non-consensual sex will be interpreted differently depending on the relationship of the victim to the perpetrator, the ages of those involved, prevalent social notions of gender roles in decision making around sexual matters (and) the circumstances in which it occurred (p. 1232)[459].*

Additionally, some participants might find it difficult to quantify their abuse and its frequency (too many over too long a time to remember). Therefore, some participants might provide a crude estimate of IPV frequency and hence, this might lead to underreporting.

7.2.2 Causality direction

My survey study was cross-sectional. The direction of the associations between IPV prevalence and variables of interest was not possible to establish, but vulnerability, and risk of IPV to certain women might be suggested from such a method. Additionally, statements about causality could be formulated due to the time sequencing when exploring some of the socio-demographic profiles (length of marriage) and other factors discussed during the interviews (early years of marriage arguments). However, time sequencing of IPV events has been researched using daily diaries where women were asked to report daily, via telephone for two months, about the previous day's violence and home environment [460]. Although this could be suggested to jeopardise women's safety, researchers used an interactive verbal response telephone system allowing

them to report assessments at any time, 24 hours per day, while leaving no written study materials around her home.

> *If we are to understand the day-to-day reality of violence, we must "look inside the black box" and collect unbiased data in real time (p.e1)[460].*

7.2.3 Response rate

Understanding the different issues influencing response rate would inform planning strategies of recruiting large numbers of participants in studies measuring IPV. It can assist in eliminating factors that might prevent participants from taking part in such a sensitive issue (IPV). The response rate to the survey in my thesis was low. Response rate was influenced by many factors at different levels: individual level, design/conduct level, and level intrinsic to IPV subject. In this section, I explain some theoretical base related to response rate in the survey, and then I discuss the different levels explaining the response rate of my survey.

Scholars have worked to develop an explicit theoretical framework for survey non-respondent [461]. These theoretical explanations to survey participation were divided into two general groups. The first group emphasized some sort of reasoned action on the part of the potential participant, with calculations of the costs and benefits to survey participation. It relies on social exchange theory to explain why an individual fills out a survey as stated by Dillman:

> *The theory of social exchange implies three questions about the design of a questionnaire and the implementation process: How can we increase rewards for responding? How can perceived costs be reduced? How can trust be established so that the ultimate rewards will outweigh the costs of responding? (pp.14) [462]*

Therefore, by offering some incentives with a survey, the researcher can increase the benefits and reduce the costs of survey participation in the hopes of increasing the response. In the survey study, I could not offer any incentive with every questionnaire posted because it would be costly and did not have enough funding (400 participants as the calculated sample size). However, at the end of my survey, every participant was offered a £20 voucher if she agreed to be interviewed.

The second group emphasized a psychological approach by viewing the decision to participate as a heuristic one, meaning that the potential participant used a set of simple rules to determine survey participation instead of devoting large amounts of thought to the decision to respond:

> *The survey request situation most often favours a heuristic approach because the potential respondent typically does not have a large personal interest in survey participation and, consequently, is not inclined to devote large amounts of time or cognitive energy to the decision of whether to participate (pp.480) [463]*

Low response rates in any survey have been examined systematically. One of the interesting observations was that in IPV surveys the response rate in Asian or Asian British population was 41% (43% in my survey) compared with 61% for white people [464-465]. This could be explained by the conservativeness of these communities, particularly, when it comes to the invasion of the privacy and the possible negative effects on the woman. This could be avoided by ensuring the confidentiality and privacy of participants in order to gain their trust.

The silence expressed by majority of my participants in not reporting the abuse to the authorities, during the interviews, might relatively explain the general Saudi women's attitudes of reluctance to disclosure. Hence, this could explain the low response rate in completing the survey in the first place.

Another explanation for this low response rate could be obviously the unwillingness to participate, for others, the stigma that some women attach to concepts of declaring abuse may reduce their willingness to be involved in violence research. This is in accordance with the evidence suggesting that response rates in studies addressing sensitive issues were low [466]. To improve this, I assured my participants that their answers would be anonoymized and kept in confidence.

Efforts to explain the low response rate in IPV survey has been carried out by researchers such as investigating the characteristics of non-respondents. A study

showed that non-respondents were women, who were 40-49 years of age and most likely did not experience abuse during their childhood [467]. Their results showed that gender-specific regression models accounted for only 5% of the variance in the response status variable, even after the inclusion of a comprehensive range of predictors in the model. Therefore, researchers concluded that a low proportion of the variance in survey participation was explained by the variables included in the analysis such as age, education, and employment status, suggesting that socio-demographic and violence-related variables might not be the main factors determining participation in the survey [467]. This study suggested that factors related to individuals might be less important when explaining the response rate to IPV, and one should look for other external factors such as the design and/or conduct of the research and factors intrinsic to IPV as a sensitive subject. I discussed these factors in the following sections.

Response rates to mailed surveys using random sampling are usually low (around 30%) compared to convenient sampling, and hence, other additional measures are needed to increase this rate [353]. I used stratified random sampling method in order to ensure that every Saudi woman in the UK had an equal chance to be recruited in the survey. The initial response rate was low (32%), but the use of other strategies synergistically (as discussed in the below and above sections) increased the response rate to 43%.

The only data available to compare respondents and non-respondents was the index of deprivation, which was not sufficient to draw any conclusive evidence of such differences. The database of the Embassy about Saudi population was not designed for research purpose, and it was found to be incomplete and some addresses were out of date and incorrect. This would imply that the intended participants did not receive some of the questionnaires sent. This has been addressed by Saunjoo and Claydell pointing out that researchers often cannot tell the difference between a non-respondent and a person who did not receive the survey because of an outdated address [468]. Another problem was that when

women contacted by the embassy officers, as randomly selected according to their postcode (N=1000), some were found to have incomplete data (n=287), these could have been replaced by another randomly selected sample to cover this defect, that might have increased the response rate. This could have provided a larger sample size and increase the accuracy and generalizability of my results. Unfortunately, this was difficult to conduct as there were difficulties faced by the embassy officers who were contacting women during the recruitment (time and effort to telephone women, convince, answered queries about study, and explain the study aims and objectives). In addition, it required a further period to recruit (restricted further by the need to meet the three years deadline of a PhD), and this would have incurred additional cost paying for the extra hours utilized by the officers to contact more women. The uncertainty remains also about the foreseen equivalence or response obtained from this extra effort and time in recruiting more participants.

One heuristic factor that could play a role in survey non-response is by featuring a kind request for help by filling out the survey in the cover letter accompanying the questionnaire. In my thesis, this was done when the survey and information sheet were prepared. This kind request for help to my participants was clearly emphasised in both the information sheet and the survey first page when instructing them about how to complete the questionnaire.

An important distinction is between declining to participate by some women and failure to establish contact with others. Declining to participate has many reasons and understandable in a survey of a sensitive matter, but failure to contact is an important added contributor to the equation of an overall response rate. I made considerable efforts to reduce non-response by making multiple attempts at contact through repeated calling (four attempts by telephone). During these calls, women were introduced to the project aims and objectives. This method has been suggested to improve response rate [469]. Other resources were also used to increase the response rate, like advertising in the web-site of the Embassy encouraging women to take part in the survey, and this along with the use of reminders to non-respondents had improved the response rate. Additionally, knowing the movement trends of the Saudi population residing in the UK around

the year helped in choose a time for mailing the survey when people are more likely to respond. However, this was sometime unavoidable as I was restricted by the project deadline with regard to the specified recruitment period that included some of the holidays, for example: Eid and Ramadan times. Other measures I used to increase the response rate included: anonymous questionnaire where participants remained unidentifiable, use of introductory official covering letterhead, and use of a self-addressed stamped envelope to return the completed questionnaire.

The stigmatised nature of IPV and fears for safety have been suggested as explanations for the low response rate in IPV surveys. Krantz and Ostregren pointed out that woman's experiences to violence is a sensitive piece of information, which she might be hesitating to reveal [470]. Fears from partners discovering the women's involvement in the survey might prevent some from taking part. WalterMaurer and colleagues emphasised the consideration of the threat for future harm when women reveal IPV and the potential result of a refusal to reveal IPV on participation in a survey [471]. They also showed that willingness to participate showed a significant dose response when measuring IPV based on the two objective criteria, type and severity of abuse, in that as the level of abuse increased by type and severity, the proportion of women willing to participate declined.

Moreover, women may refuse due to anxieties about reporting highly sensitive personal issues via someone who has the power over other areas of their lives (Embassy). The Saudi Embassy in London is a governmental body and exerts similar rules and regulations that are usually applied in the homeland of Saudi Arabia with restrictions on issues related to women. For example: if a woman' male guardian refuses for her to continue her postgraduate study in the UK and asks to terminate her scholarship, the Embassy will provide this to him without considering the woman' need to study.

7.2.4 Generalizability of the thesis findings

Generalisability does not only depend on the number of participants but it also on the representativeness of the sample. In the survey study, I used a stratified random sampling technique that was based on the multiple index of deprivation (IMD) of the various areas in the UK. This advantage of randomisation has been emphasised by Polit and Beck:

> *a selection process in which each element in the population has an equal, independent chance of being selected (pp.295) [472]*

Hence, this might make the study findings relatively generalizable to other Saudi women in the UK. However, there is a reason against generalizability of the survey which is based on that other socio-demographic factors was limited by the information available in my sampling frame (Embassy database) that was regulated by the data protection act in the UK. Therefore, legally, I have limited access to the non-participants' characteristics that could allow me to use in comparing them with the respondents. Additionally, I understand that obtaining further information was un-ethical, and I had to find other methods to compare the respondents with the non-respondents.

Socio-demographically, using the Index of Multiple deprivation score, there was no statistical significant difference between the respondents and non-respondents. However, this score represents UK socio-demographically, which might not necessarily reflect the section of Saudi women living in the UK. This is because the Saudi population site of residence in various parts of the UK could be based on the job, business, or education assignments that limited their choice and unrelated to their socio-demographic status, (the same might be for UK people). Moreover, IMD is based on ecological means and might have poor relation to Saudi socio-economic status. Therefore, this comparison between respondents and non-respondents might not be sufficient to reflect the representativeness of my sample.

With regard to the interview's study, Silverman suggested that purposive or theoretical sampling could be used to overcome the dangers of purely anecdotal

qualitative research and to strengthen transferability of the findings [473]. In my qualitative interview study, I used purposive sampling to gain a diverse sample in an effort to explore Saudi women's experiences of IPV in the UK. Qualitative interviews are meant to discover meanings and understanding rather than to verify truth or predict outcomes. Additionally, I have reflected on my role as a researcher (chapter 5 and this chapter) in the design, process and analysis of the interviews' data in an attempt to avoid excessive generalizing claims as Payne and Williams pointed out:

> *By starting with more reflection on the end point of the research process researchers should be better placed to adapt their research designs, so avoiding excessive generalizing claims, and engaging actively with expressing their more modest claims in clearer terms. (pp.311) [474]*

7.3 Strengths

Strength of the translation and adaptation study was its concordance with international guidelines on translation. This involved initial forward translation, expert panel translation, focus groups translation and refinement, independent back translation, and refinement of the survey questionnaire. The multi-staged and structured process of translation and adaptation ensured the face validity of its items in Arabic. The multiple contributions to the translation, adaptation, and refinement of the survey items (by the expert panel, focus groups, and an independent translator) enriched the critical review of the whole survey instrument and increased the likelihood that the questionnaire was appropriate for Saudi women.

A novel aspect of my thesis was the empirical cross-level estimation and explanation of interactions between the prevalence of IPV, socio-demographics, health status, experiences, beliefs and attitudes of Saudi women exposed to partners' violence. To my knowledge, there are no previous efforts that simultaneously approached IPV in a similar method that was used in this thesis. Using a mixed method approach was one of the important strengths that broadened the understanding of IPV in integrative multi-contextual levels among Saudi women in the UK. This is because mixed methods allowed me to answer

the multiple questions and issues surrounding IPV and increased our understanding of the nature and magnitude of such violence. Subjective narratives of women added some meanings to the figures resulted from the survey, while these numbers added some precision to the narratives.

This pragmatic concept of mixed methodology approach has been emphasized by previous researchers defining this as an intersectional theory within which to study violence in immigrant communities [475-476]. They explained that the abused women's oppression is often multiplied by their residence at the intersections of particular race, class, ethnic, sexual orientation, gender, and immigrant systems of oppression and discrimination [477]. Intersectionality is a way of considering all the factors that together make up our identities (for example, Muslim and Arabs), status in society, our age, and our gender [478]. These connections of factors were revealed by the experiences of several of my participants expressing the role of culture/religion in ruling their lives, their sub-ordinate status in the society as divorced women, and political identity (Saudi & obligations to its cultural values) in creating further disempowerment of women. Another added strength of the interviews lies in the structuring of the themes by the temporal order of the experiences of IPV, women's beliefs and attitudes, their response to abuse, and the bio-psycho-social impacts on their lifetime.

The majority of intersectional research is done using qualitative methods. However, the strength and novelty of this thesis lied further in embracing quantitative techniques to highlight the intersectionality perspective (my survey). This concept emphasised recently the need for quantitative analyses to account for intersectionality theory with survey data, and pointed out that interaction terms as the best way to measure intersections [479]. In my ecological model, I emphasised the interactions between the components of the framework. The survey study analyses the interactions (associations) between IPV and socio-demographic profiles. While in the qualitative interviews, data analysis highlighted the interactions between IPV and different aspects of women's experiences (culture, religion, social values, economic factors, law, and health impacts). The integration

between these two types of data (survey and interviews) was a relative effort of accountability of intersectionality in my analysis. However, the challenge remains now in strengthen the connection between the theory of intersectionality and quantitative techniques in a follow up longitudinal studies allowing more robust evidence about IPV and related factors observed over a period of time.

One of the strengths also in this project is the use of a well validated tool (the CAS) that measured the types and severity of different types of IPV. Additionally, it was adopted and translated by Saudi women living in the UK and experts who shared similar cultural and religious background with Saudi population. Moreover, the interviews were conducted by me, and I was privileged to be a female doctor who came from the same socio-cultural background. This allowed me to understand the language, culture, and the social values these women held and expressed during the interviews.

7.4 Limitations

This thesis had a number of limitations. Concerning the first study, there were some limitations in the translation of the CAS and adaptation of the survey questionnaire. One of the limitations was "construct bias." This occurs when the construct measured is not identical across cultural groups [340]. For example, the concept of adult partnership is broader in the English language and culture than the domain covered by Arabic. Boyfriends, unmarried partners, and same-sex partners are included in the conceptions of the life of the English culture. In Arabic cultures, it mostly denotes a husband or fiancé. However, one cannot deny the effect of globalization that might have a role in changing social, cultural and even religious beliefs and norms among the current Saudi generations, where women and men have the opportunity and capacity to practice Western norm and customs.

In my survey study, the cross-sectional design did not permit proof of causality between violence by intimate partner and health problems and other socio-demographic profiles (women's age, women's education, partner's education,

number of children, length of marriage, and length of stay in the UK). Nevertheless, the findings gave an indication of the types of association, and the extent to which different associations were found. In other words, the results of estimation and relationships between various types of IPV and other suggested factors were not due to the cumulated effects, which could be obtainable in prospective follow-up population studies in order to explore the causal pathways between IPV and other factors of interest.

Another limitation is that the validity of self-report measures as a method of identifying perpetrators or victims has been questioned in the past for their difficulty in guaranteeing accurate responses and their susceptibility to socially desirable response [480]. Schwartz pointed to the increasing interest in ascertaining the continuous evaluation and modification of survey methodology and terminology of IPV through question rewording and ordering and consideration over the telephone versus face-to-face interviewing [481].

Although the Arabic SF-36 health survey was a valid and reliable population tool, the finding of health status measurement by this instrument was limited to assessment of broader health indices, and could not provide disease specific outcomes but can only assess the overall bio-psycho-social well-being of participants. Health problems reported in the survey study could be the result of many different reasons, for example: several women I interviewed were pregnant and during such time, women expected to have many symptoms and signs that could not be specific to the pregnancy itself or as consequences of IPV such as headache, and fatigue. The physical functioning scale poses questions about interpretation. Questions ask whether your health limits you in "rigorous activities such as running, lifting heavy objects, particularly in strenuous sports" or "in walking more than a mile." It is not clear how those who never participate in such activities should respond, their health might be severely impaired, and yet they should respond "no, not limited at all" and will therefore receive a score indicating better functioning than might be expected. Additionally, other problems include lack of full completion because of lack of respondent's lack of

comprehension, illness, the researcher's lack of control over question order effect (respondents can read through the questionnaire before completing it and therefore, their response is biased), lack of motivation and variable time periods of completion [373].

Another limitation is that the sample might be biased including a highly educated section of the Saudi women population, and this may have an effect on their response to the survey, and their perceptions and experiences of IPV. This bias might have resulted in not only a sample with a lower prevalence of IPV, but also explained the accounts of many empowered, negotiating, and rationalizing participants expressed during the interviews as they were educated.

Concerning the qualitative study, men's views were not provided for the interviews' analysis, hence, findings from the study should be considered as suggestive. Analysing qualitative data presents some noteworthy challenges to the ecological priority of levelling the balance of power between the researcher and participants [258]. Obviously, the participants did not participate in the data analysis stage of the qualitative study, and subsequently did not have the same level of control as the researcher in interpreting the main themes emerging from the data. Furthermore, interpretation of the findings from an ecological standpoint was my choice, as was the selection of the particular excerpts to be reported as direct quotations in the results. I also had the power to choose which of the participants' perspectives would command particular focus according to the research questions and theoretical approach. During the data analysis stage, I attached meanings to the participants' experiences, which the participants might or might not have aligned with.

Another limitation of my thesis was the low response rate to the survey (43 %) despite that, multiple efforts were applied to the recruitment process (detailed in previous section: response rate 7.6.3).

Having discussed the thesis findings and highlighted some of its strength and limitations, I will express my reflection regarding the whole period of conducting

my thesis and then end with the conclusions and implications of my thesis in the next sections.

7.5 Reflection

In this section, I discuss my ideas, feelings, and reflections in a chronological and narrative manner from the start until the submission of my thesis.

Researching IPV was not only challenging at the beginning, but for me was a risk studying such a stigmatised issue for my society, but also I felt it was imperative to break the silence among Saudi population in order to join the international voice. I was not brave enough to conduct it in my homeland, as I did not expect the ethics committee of my institution to approve it. Additionally, I still believe that the research advancement and the society in Saudi Arabia are not yet fertile enough to absorb such a sensitive private and difficult health problem. In Saudi Arabia, the health organizational context where I work could limit and restrict how I go about investigating my research question, particularly when touching a controversial issue. IPV is private and complex in every aspect. It has a private vocabulary, which, in addition to strictly sociological terms, includes new words for the commonest actions, feelings, and circumstances surrounding its process, such as mutual couple violence.

The general direction of my methodology was looped around with multiple cycles of inquiry (translation of CAS, survey, interviews) as a means of drawing closer to the essence of what I was seeking. These cycles were informed by my literature review, my supervisors' feedback, listening to experts on IPV field, and dialogue with myself of what I can and have to do. Closure of this process within the thesis came when a coherent conceptual framework was adapted. At the beginning, I believe I had some sort of a framework with some contents. I mean a model that described the process of designing, planning and carrying out my research. Then the findings would supply more or eliminate some 'content'.

As a general practitioner by profession and advocate of evidence based health care, I inherited the habit of systematically structuring any activity (research is

one) on a daily basis. Moreover, as a female Saudi individual who inherited also the same socio-cultural norms and values of my participants, I constituted one of the contextual factors that were contingent on carrying out the research. However, there are individual differences between my participants and myself and in between my participants. I did not want to be confirmatory of my instincts that IPV is common and highly prevalent as I predicted from my clinical work and avoid what might challenge my prior beliefs (that IPV is not common). It was a stage of mixed feelings and thoughts that ended up with the adaptation of a mixed methodology approach. Decision about the methodological approach was also guided by the theoretical perspectives given from the literature review. Experts emphasized that one of the difficulties a researcher face is to disentangle the numerous theoretical points of view that come across and make sense of these for one's own research [482]. My literature review informed my methodology and my conceptual framework by enriching my understanding of how to investigate IPV.

Throughout my journey, I had some presumptions, beliefs, challenges, and difficulties. For instance, I should admit that my initial pre-conceptual over-estimation of IPV prevalence as a GP might add to one ambiguity to the over-estimated sample size calculation before conducting my project. Although my sample size calculation was statistically correct and based on previous studies conducted in Arabic/Muslim countries, there might be an error, as these studies differ in their methodology and instruments used to measure IPV.

One of the challenges was to master the academic social science English language, rather than the clinical English language that I get used to it since I have been in medical school. However, it was relieving to me that even my native English-speaking friends found it difficult to master.

It was very interesting moments when I had the survey instrument born and ready to be delivered to my participants after several months of ebb and flow. I was optimistic with very high expectations that I will get a large response, but winds runs against what ships want, and I had to struggle to increase the response rate morally and ethically as possible as I could. Nevertheless, thanks God, I was backed up by the Saudi Embassy efforts and support from my supervisors who suggested different strategies that involved an iteration process of moving from

one stage to the next and then back again until I reached a final stage where I thought that I could not force women participating in my study, but to accept my 43 % response rate. I understand that there was no point in carrying out research that does not challenge me and stretch my abilities; as they say: no pain, no gain. The low response rate was one of my challenging painful moments that I faced during my three years thesis period. After I had the results of the survey and interviews, I felt I had to combine coherently these different findings in an integrated meaningful way, considering each, without privileging one account over any other.

Having so much data from the twenty interviews seemed at the beginning to me an impossibly research problem. However, after starting the process of coding and categorization, I was able to see the joy of such exercise, and intellectually became engaged to complete this interesting analysis of these qualitative data. In addition, IPV is a wide-ranging topic, and I could not flit from one aspect of the interviews' data to another without being forced to think of, re-read, refine and test each piece of analysis. Consciously, and sometimes sub-consciously, survey results (prevalence, associations, modelling) were intrusively interrupting my thread of thoughts when reading and analysing the transcripts of the interviews trying to find what all this is about? Nevertheless, I did overcome this by staying close to the data and concentrating on what my participants said. The interview stage carried some difficulties as some interviews were conducted in Arabic, and I had to listen and translate from Arabic into English simultaneously in order to discuss and communicate the transcripts with my supervisors. This was complicated by my assumptions and beliefs that I mentioned above before collecting the interview data, adding another challenge to the synthesis of my findings. To overcome this, I tried to approach my data with an open-minded manner, putting aside my pre-occupied thoughts and beliefs, supported by my supervisors who shared their views and comments about my data.

I could not suppress my feelings that there were some sort of particular and different distinctions regarding the issue of IPV among Saudi women, which could characteristically and might be uniquely spotted from the findings. These

characteristics could be in the form of meanings, explanations, or associations that could feed into a theoretical model, which could be tested in a further longitudinal follow-up research allowing a higher hierarchy of evidence that either supports or contradicts such a model.

The conclusions of my thesis and the subsequent implications (discussed below) were obviously out of the Saudi context in a national sense as the research was conducted in the UK. However, we are living in a massive expansion of globalised communication where we are expected at all levels and in every subject to bear in mind that what happens in one side of the world can influence the other side. As a member of the Saudi community, I guess it would not be easy for its members to switch their religious values and norms off to live in another context with different standards of values that might still hold a critical view about Saudi communities. Therefore, the results could be a relatively valid cross-sectional portray of IPV among Saudi women in general terms.

I leave this thesis with the hope of being able to continue researching IPV in my homeland in order to join the ongoing worldwide efforts to tackle such violence.

7.6 Conclusion, policy implications, and future research recommendations

This section includes my thesis conclusions, policy implications, and future research recommendations. Here, I discuss the conclusions, policy implications, and recommendations, starting from the translation of the Composite Abuse Scale (CAS) and adaptation of the survey questionnaire, to the survey and interviews conducted among Saudi women living in the UK.

7.6.1 Thesis conclusions

As a main part of my conclusion, the thesis had achieved its aim and objectives, despite some reservations, by using a robust mixed methodology structured by an ecological framework, and analysing and discussing the data in light of its components. The present thesis extended the current body of IPV research in a different context, by studying an under-researched group of Saudi women, who

have had little research focused on their experiences or exposure to IPV. In addition, the findings might suggest some background basis to more rigorous informed future research efforts in the field of IPV among Saudi women.

The translation of the CAS and adaptation of the survey questionnaire constituted an essential component of my thesis in preparation to conduct the survey. The structured approach in translating the CAS and adapting the whole survey questionnaire was a successful as well as challenging step that involved multiple methods of translation, including: initial forward translation, experts' panel discussion, focus group discussions, back-translation, and final refinement of my survey questionnaire

Both perspectives (survey and interviews) were reconciled representing an integrative conclusion that fulfilled my research objectives in establishing the prevalence, experiences of IPV, and the associations of such violence with the socio-demographics and health status of Saudi women living in the UK.

Severe combined abuse was the most prevalent type of IPV (19%), while physical abuse was the least prevalent (2%). However, these prevalence rates might be underestimated because the majority of my interviewed participants were silent and did not ask for help.

There were no associations between some previously proven explanatory factors, such as age, and the prevalence of different types of IPV. However, lack of evidence of such an association is not evidence by itself, as further population studies with large sample at various settings could reveal such associations.

Data from the survey and interviews represented only the psychological, biological, and social status of the respondents at this cross-sectional time with certain objectives, measures, and methods, and might not be a true representation of their bio-psycho-social well-being over time. Therefore, longitudinal studies with long follow-up would provide more accurate and precise estimates of the changing pattern of women's well-being that are exposed to IPV. The relationships between IPV and health status remained complex and challenging to

researchers and hence, this motivated further efforts in determining the level of the cause and effect of these associations in longitudinal follow-up studies.

Saudi women in the UK had more or less reproduced a cultural script of IPV. The majority of participants during the interview asserted that culture and social values superseded the Islamic regulations as a religion in shaping Saudi individuals' beliefs, attitudes and response to IPV. These women highlighted that if religion applied to the life of partners, women would not be exposed to IPV. Therefore, religious emphases on compassion, justice, and liberation in a variety of faiths could be modified in opposition to violence against women [483]. Conservative Islamic interpretations contributed to this problem of harsh constrains on women, and more progressive interpretations of Islam can be part of the solution. I join my voice with my participants and those who support Islamic feminism in harnessing the power of religion for change, rather than working against it.

Social values facilitating and/or preventing IPV, economic hardship, fear of losing their children, religion, self-pride, and supportive legislations to IPV, were all factors that played part, individually and/or in combinations, in women's decision in staying or leaving their abusers. Participants emphasised the notion that IPV was much more than a violence issue for them but rather an issue for their entire family.

Awareness, negotiation, counselling had contributed to some women's survival. Survival was promoted by various health professionals, faith in God, friends, and family. The perspectives explored here offered some tentative suggestions for the present violence services in the UK. These services could be formed and developed for further research among Saudi living in the UK such as public awareness and education campaigns with special insights and emphasis on the socio-cultural contexts of the Saudi community in order to support and protect women from further IPV. The findings of my thesis, especially the narratives that described women's definition and perceptions of what constitute IPV among Saudi women could inform the development of a culturally sensitive IPV

instrument. This instrument could include items such as: whether having sex without their consent is right or wrong, fear of God's punishment if women do not obey their husbands, and assess whether being married to a relative could protect them from violence or not. These items could be incorporated into a survey and/or interview studies in order to capture the multi-dimensional complex aspects of IPV. Such items would increase our understanding of the nature of IPV in different cultures and subsequently allowing more sensitive and focused support and help resources to abused women.

The results also were consistent with some of the theoretical elements of the thesis ecological framework, and this might suggest developing a hypothetical, culturally specific theory that would integrate different threads and portrayed the range of influences of IPV on Saudi women's process of change to their bio-psycho-social well-being. This could allow understanding Saudi women's varied responses to IPV. Among Saudi women in the present thesis, IPV was surrounded by social, cultural, religious, and personal aspects that defined its inception, process and termination. Saudi women are the only women in the world who are not allowed, legally, to join school or university for education, travel, or socialise without their male guardian permission. Therefore, the data from the survey and interviews point towards a suggested ecological model based on the analysis and interpretations of some of my data and drawing on the original Heise ecological framework [209].

The present thesis suggested that a shift of focus from the single site of human interactions (prevalence of IPV) to the multiple levels of socio-demographic, health, cultural, economic, and political realms would offer a number of promising analytical possibilities (associations, impacts, and in-depth qualitative exploration of IPV experiences). This use of a structural methodological and analytical framework in my thesis emphasised the importance of structural forces in the women's lives that experienced IPV and subsequently could suggest a change in tactics and strategies by which to respond to IPV. Relating the different socio-demographics, cultural, economic, political, and health outcomes to IPV

opened a space for a broader research agenda to emerge that considers a fuller picture of hierarchical influences. Connecting these issues to IPV prevalence and experiences would contribute to the existing scholars and activists' efforts, linkages that are required to problem-solve against IPV globally.
Outcome of my thesis extended to benefit some Saudi women who took an active strategy and ended their abusive relationships as they informed me recently. Many of my participants also expressed how this research empowered them and made them aware of their situations and resources available to them for help.

In summary, the silence and shame of IPV victims suggested that it is challenging to generate reliable estimates about its prevalence. A few socio-demographic characteristics define risk groups for intimate partner violence. IPV prevalence and experiences are full of complexity and conflicting evidence. Social acceptability of IPV, cultural norms and governmental legislations support IPV among my informants. Economic constraints played a role in whether women could remain out of their abusive relationships. Therefore, researchers are encouraged to assess the immediate antecedents and broader cultural and relational context in which the violent individuals are situated. Victims and Saudi community at large would benefit from increased awareness of the dynamics of IPV and the need for coordinated action. Schools are a natural setting for early preventive programs, such as awareness and education about proper gender relationships, to begin long before intimate relationships begin to form.

7.6.2 Policy implications

From my thesis findings, several policy implications could be suggested. Language, attitude, and cultural variations of IPV should be considered when preparing policies and legal regulations concerning such violence, particularly in the UK where multi-cultural populations are increasingly existing. This could be done by providing culturally sensitive, informed, and specific policies, particularly for Saudi women. Saudi women are facing specific legal problems with their partners, for example, if a partner chose to terminate a woman' post-graduate scholarship, he could do this by writing a letter to the Saudi Embassy, leaving her to face the University regulations where she studies. Such difficult

situations need to be tackled by the UK governmental policies to prevent such a severe type of abuse. Saudi and UK governments have a long history of economic and political exchange, which could facilitate the negotiation and influence from the UK in order to prevent such unfair practices.

Incorporating health-related items to IPV scales in population studies and studies conducted in different health settings could help plan strategy to manage the problem itself and its impacts. For example, strategies to tackle IPV problem should address the health needs of its victims. This would help in characterising and defining in need groups of women exposed to IPV.

Family honour and need of reserving its traditions were concerns for many of my participants. This family centred perspective highlighted many complex needs that must be considered if IPV resources to be improved for Saudi women in the UK. Policies and regulations regarding IPV in the UK needs to consider these sensitive individual and familial issues when tackling cases of abused Saudi women living in the UK. Informing, empowering and supporting abused Saudi women might be the appropriate approach when managing IPV, rather than a clash with the deeply rooted cultural practices that oppressed them for centuries. Policies working to empower Saudi women would help them to recognise their roles and motivate them in breaking their silence and defending themselves in an informed and protective manner.

Other policy implications of my thesis include the recognition of the importance of Islam as a religion and its detrimental role in the lives of Saudi women, in particular, and Muslim women in general. Use of Islamic arguments to reform discriminatory laws against women is a strong step towards preventing IPV. Hence, policies and regulations regarding IPV in the UK perhaps need to consider these arguments in an effort to communicate with Muslim communities when tackling IPV.

7.6.3 Future research recommendations

Although I followed a structured and systematic process in the translation of CAS and adaptation of the survey questionnaire, cross-cultural validity of the Arabic

CAS remained unclear. Therefore, in addition to my recommendation of using my Arabic version of CAS for future research, future research should involve further validation and reliability tests to ensure its accuracy, and acceptability to different Arabic and Muslim cultures. This is due to the fact that IPV is a changing and complex issue, which needs similar or even more rigorous methods in various settings to measure its prevalence and explore its meanings and experiences. Translation research should take into consideration the changing and globalizing nature of the Saudi population regarding the language, meanings and attitudes towards IPV in their homeland or abroad.

The prevalence and experiences of IPV obtained from this thesis provided guidance to future research and help in planning its aims and objectives. It provided a solid platform for future research investigating IPV among Saudi women in the UK or Saudi Arabia. However, this was not the complete truth, but an illumination of a possible truth, and I believe it was 'work in progress' and therefore, subject to change in future research efforts because knowledge about IPV is neither static nor certain.

My thesis findings suggested that some methodological, individual, psychological, societal, cultural, economic and political issues might also explain the reported prevalence of different types of IPV. Therefore, these issues must be considered in further research efforts to investigate IPV in order to be comparable to other countries reported prevalence. The links between the elements of physical, psychological and social impacts of IPV encourages the routine incorporation of health-related items to abuse scales in both population studies and studies in various health settings. Therefore, abused women would not only be identified, but their well-being and health needs simultaneously. Thereby, the focus of future researches in IPV should be on heterogeneity in evidence synthesis (prevalence and impacts) rather than identification of central tendency of certain figures. I suggest that future research efforts in investigating IPV should include items about the bio-psycho-social status of abused women. I also recommend applying an epidemiological measure of IPV prevalence and health status, with

qualitative studies as the best way of understanding impacts and needs of abused women.

Interview findings addressed the way that specific acts and policies operated together to create women's disempowerment at various individual, social, economic, and political levels. In fact, these levels often overlap and cross over each other, creating complex intersections at which two, three, or more of these levels meet. However, further research is needed to address the degree of intersectionality of these levels using longitudinal follow-up studies quantitatively and qualitatively and to allow understanding the changing pattern of IPV over time. This could be done by conducting multiple consecutive in-depth interviews with abused women, as well as survey to assess the degree and extent of interactions between IPV and other postulated factors that could play a role in it occurrence over time.

There is a need for further follow-up prospective studies to explore the direction of causality of associations between IPV and various socio-demographic profiles as well as health status of abused Saudi women. Additionally, there is a need to expand IPV survey research paradigms that define IPV as encompassing measures of behaviour and associative or situational socio-cultural contexts such as culture and religion. If IPV is based on the pattern of behaviours, that might be driven by economic hardship, influenced by the family, and yielded consequences perceived by the women, and then measuring only the act, it would be insufficient to, precisely, measure the process of a particular IPV. Precision of measuring IPV would be optimal if the process of such violence was explored in future research from multi-dimensional aspects in line with the ecological framework that structured my thesis.

A final recommendation is to investigate IPV among Saudi women, using a larger population-based study, in their homeland in future research, which I would be honoured to take part in conducting such a project. This would allow measuring and understanding of the extent and nature of IPV in the real individual, social, familial, economic, and political environments. This needs strong determination,

courage, and persuasions to face the possible academic, social, and political challenges one could face when deciding to study such a sensitive issue.

Appendix 1: Table of critical appraisal of CAS translation studies

Cross-cultural adaptation Design requirements	(Study 1)	(Study 2)	(Study 3)
1.Was the percentage of missing items given?	Not described	Not described	Not described
2.Was there a description of how missing items were handled?	Not described	Not described	Not described
3.Was the sample size included in the analysis adequate?	32=fair	Fair	Not clear
4.Were both the original language in which the instrument was developed, and the language in which the instrument was translated described?	Yes	Yes	Yes
5. Was the expertise of the people involved in the translation process adequately described? e.g. expertise in the disease(s) involved, expertise in the construct to be measured, expertise in both languages	Yes	Not reported (authors e-mailed)	Not reported
6. Did the translators work independently from each other?	Yes	?	Not described
7. Were items translated forward and backward?	Yes	Yes	Yes
8. Was there an adequate description of how differences between the original and translated versions were resolved?	?yes=good	?	No
9. Was the translation reviewed by a committee (e.g. original developers)?	Yes	?	Not described
10. Was the instrument pre-tested (e.g. cognitive interviews) to check interpretation, cultural relevance of the translation, and ease of comprehension?	Yes	?	No
11. Was the sample used in the pre-test adequately described?	?yes	?	No
12. Were the samples similar for all characteristics except language and/or cultural background?	Not described=fair	?	Not reported
13. Were there any important flaws in the design or methods of the study?	Fair		Not sure
Score	Fair	Waiting for e-mail response	Poor, waiting for e-mail response

Appendix 2: Search strategy

1.spouse abuse

2.apouse abuse.tw

3.battered women

4.battered women.tw

5.domestic violence

6.domestic violence.tw

7.1 or 2 or 3 or 4 or 5 or 6

8.prevalence studie$

9.prevelence studie$.tw

10.incidence studie$

11.incidence studie$.tw

12.8 or 9 or 10 or 11

13. wom#n

14.wom#n.tw

15.female$

16.female$.tw

17.13 or 14 or 15 or 16

18.Muslim$

19.Muslim$.tw

20.18 or 19

21.Arab$

22.Arab$.tw

23. 21 or 22

24.7 and 12 and 17 and 20 and 23

Appendix 3: Summary of survey studies of literature review

Study ID	Setting	Results	sampling	Study size	Response	Discuss generalisability	CI	↓Bias	Score
Haj-Yahia, M. M. (2000). "The incidence of wife abuse and battering and some sociodemographic correlats as revealed by two national surveys in Palestinian society." Journal of Family Violence **15**(4): 347–374, population study	Palestine	Annual incidence; **E**; 52%,**P**; 52%, **S**; 37.6%, **EC**; 45% Tool: developed using CTS, measure of wife abuse, the psychological maltreatment of women inventory, Index of spouse abuse, and the abusive behaviour inventory	Random	2800 , 1500	86.7%, 88.9%	Yes	No	No	6
Mousavi, S. M., and Eshagian, A (2005). "Wife abuse in Esfahan, Islamic Republic of Iran, 2002." Eastern Mediterranean Health Journal **11**(5-6): 860-869, population study	Iran	LT overall; 36.8%, Incidence; 29.3%, **P;** 27.2%, **E;** 32.4% Tool: developed by researchers	Random	386	87.5%	No	No	Yes	5
Khawaja, M., and Barazi, R (2005). "Prevalence of wife beating in Jordanian refugee camps: reports by men and women." J Epidemiol Community Health **59**(10): 840-841, population study	Jordan	LT **P**; 42.5%, C; 17.4% Tool: not reported	Random	262 (women)	95%	Yes	No	No	4
Hassan, F., Sadowski, LS, Bangdiwala, SI, Vizcarra, B, Ramiro, L, De Paula, CS, et al (2004). "Physical intimate partner violence in Chile, Egypt, India and the Philippines." In J Control Saf Promot **11**(2):	Egypt, India, Philippine, Chile	**LT; (P)**: (Egypt); 11.1%, India= 34.6%, Philippines = 21.2%, Chile= 24.9% **C; (P):** Chile= 3.6%, Egypt=10.5%, India=25.3%, Philippines= 6.2% **LT; E;** Chile= 50.7%, Egypt= 10.5%, India=24.9%, Philippines=19.3%.**C; E;** Chile=15.2%, Egypt=10.8%,	Random	422 (Chile), 631 (Egypt), L; 506, T; 700, V; 716, 1000 (Philippine	96.1%(Chile), 93.5%(Egypt), 88%(India), 100%(Philippine)	Yes	Yes	Yes	7

111-116, population study		India=16.2%, Philippines=4.8% WorldSafe standardized instrument		s), Brazil=813					
Raj & Silverman 2002, population study	South Asian women in Boston	C **P**; 26.6%, **S**; 15%, LT**P**;30.4%, **S**; 18.8%	Snowball?	160	Not-reported	Yes	No	No	3
Kocacik et al 2006, population study	Turkey	LT**E**; 53.8%, **P** 38.3%, **S**;7.9%	random	583	100%	Not reported	No	No	5
WHO, Garcia-Moreno et al, 2006, population study	Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa (National), Serbia, Thailand, Tanzania,	**Bangladesh**: LT (**P**: 39.7%, **S: 37.4%**), C (**P**19%, **S: 20.2%**) 2-**Brazil**: LT (**P**27.2%, **S** 10.2%), C (**P**8.3%, **S 2.8%**). 3. **Ethiopia**: LT (**P**48.7%, **S 58.6%**), C (**P**29%, **S 44.4%**). 4. **Japan**; LT (**P**12.9%, **S 6.2%**), C (**P**3.1%, **S 1.3%**). 5. **Namibia**: LT (**P**30.6%, **S 16.5%**), C (**P**15.9%,**S9.1%**). 6. **Peru**: LT (**P**48.6%,**S 22.5%**), C (**P**16.9%, **S 7.1%**). 7. **Samoa**: LT (**P**40.5%, **S 19.5%**), C (**P**17.9%, **S 11.5%**). 8. **Serbia**: LT (**P**22.8%, **S 6.3%**), C (**P**3.2%, **S 1.1%**). 9. **Thailand**: LT (**P**22.9%, **S 29.9%**), C(**P**7.9%, **S 17.1%**). 10. **Tanzania**: LT (**P**32.9%, **S 23%**), C (**P**14.8%, **S 12.8%**). Tool: developed by researchers	random	24097	Japan (60.2%), other countries range; 85%-97.8%	Yes	Yes	Yes	8, in Japan =7
Ergin et al 2005, primary care	Turkey (Bursa)	LT P; 34.1%, E; 15.8%, economic; 8.2%, all-type violence; 29.5%	Not reported	1427	71%	Yes	No	Yes	6
Burazeri et al 2005, population study	Albania	C ; **P**; 37%	Random	1196	87%	No	Yes	No	5
Mayda & Akkus 2004,	Turkey	LT **P**; 41.4%, **E**; 25.98%, **S**; 8.6%, **E**;	Non-	116	100%	Yes	No	Yes	4

population study		77.6%	Random						
Ghazizadeh et al 2005, population study	Iran	LT **P**; 38%, C; 15%	random	1040	97%	No	No	No	4
Faramarzi et al 2005, obstetric/gynecology clinic	Iran	C **P**; 15%, **S**; 42.4%, **E**; 81.5%	Non random	2400	Not clear	Yes	No	No	5
Ahmed & Elmradi 2005, medical center	Sudan	C **P & E**; 41.6%	Non random	492	86.8%	Yes	No	No	4
op-Sidibe et al 2006, population study	Egypt	LT **P**; 34.3%, C; 47%	Random	6566	99%	Yes	No	No	5
Apler , Z, Ergin, N, Selimoglu, K, Bilgel, N. Domestic violence: a study among a group of Turkish women. Eur J Gen Pract 2005, 11 (2): 48-54, primary care	Turkey	LT **P**; 58.7%, C **P**; 41.1%%, **E**; 33.6%	Non random	506	Not reported	Yes	No	No	4
Taner Akar & F. Nur Aksakal & Birol Demirel & Elif Durukan & Seçil Özkan. The Prevalence of Domestic Violence Against Women Among a Group Woman: Ankara, Turkey. J Fam Viol (2010) 25:449–460. Primary care setting	Ankara; Turkey	LT (any); 77.9%, economic: 60.4%, control behaviour; 59.6%, E; 39.7%, P; 29.9%, S;31.3% Tool: adapted from Abuse Assessment Screen	?non-random	1,178	Not reported	No	Yes	No	4
Evone Barkho • Monty Fakhouri • Judith E. Arnetz. Intimate Partner Violence Among Iraqi Immigrant Women in Metro Detroit: A Pilot Study. J Immigrant Minority Health., 2011;	Iraqi women in Detroit	Controlling: 93%, threatening;76%,P;80%	Non-random	55	Not reported	Yes	No	No	3

13 (4): 725-731, population study									
Arwa Oweis Muntaha Gharaibeh Rudaina Alhourani. Prevalence of Violence During Pregnancy: Findings from a Jordanian Survey. Matern Child Health J (2010) 14:437–445, health-setting	Irbid, Jordan	P;10.4%, E;234%, S;5.7%	Non-random	316	87.4%	Yes	No	No	5
A.A.Tashkandi and P. Rasheed. Wife abuse: a hidden problem. A study among Saudi women attending PHC centres. Eastern Mediterranean Health Journal, Vol. 15, No. 5, 2009	Saudi Arabia, Medina	P; 25.7%, E; 32.8%, P or/and E; 57.7%	Simple random	689	67.5%	Yes	No	No	6

Note: P: Physical violence, LT: Lifetime, C: Current, S: Sexual, E: Emotional, PrevPL: Prevalence of lifetime physical violence. PrevPC: Prevalence of current physical violence, PrevEL: Prevalence of lifetime emotional violence, PrevEC: Prevalence of current emotional violence, PrevSL: Prevalence of lifetime sexual violence, PrevSC: Prevalence of current sexual violence.

Appendix 4: summary of literature review of IPV qualitative studies

Study	Aim/setting/women	Method/ sample size	Findings	Notes	Future recommendations
1)Angela M. Moe. Silenced Voices and Structured Survival: Battered Women's Help Seeking. *Violence against Women* 2007; 13; 676-699.	Aimed to understand battered women's perspectives about help-seeking efforts, emergency shelter for victims of DV in Arizona	Semi-structured interviews audio-taped and transcribed, 55 min interview, 19 women (age 18-45), some pregnant, diverse in terms of race, ethnicity (clear description), analyzed using grounded approach. There was justification of choice of design,	Themes; attempting to leave; fear of abusers, feeling guilty, still loving their partners, while active help seekers, entrapped in their relationship because of failures of various agencies to assist them. Mostly seek help from friends and relatives. Another means of help seeking were to involve the legal & justice system.	Findings discussed in relation to research question & to other research-based literature. However, did not consider the relationship between researcher & participants, enough details of ethical issues, clear recruitment criteria	Need for coordinated community-response protocols that provide support and collaboration within and between various social service, victims, and criminal justice agencies.
2) Wong S. Lo Fo, F. Wester, S. Mol, R. Romkens, D. Hezemans, and T. Lagro-Janssen. Talking matters: abused women's views on disclosure of partner abuse to the family doctor and its role in handling the abuse situation. *Patient Education & Counselling* 70 (3):386-394, 2008.	Aimed to explore what women valued most in disclosing partner abuse to their doctor and whether disclosure played a role in handling their abuse situation, 36 women (aged 17-55+>56) who had disclosed abuse shortly before to their family doctor, in health center in Netherlands.	Qualitative interview (1-2H), The interview guide provided open-ended questions to encourage the woman's own answers (justify method).	Women wanted doctors to emphasize that partner abuse is not acceptable, women felt they are in a transition, in which women started the process of change and encouraged to act…clear themes and categories described	Clear ethical issue, very explicit topic guide, clear recruitment criteria, clear analysis described, Findings discussed in relation to research question & to other research-based literature. Somehow consider the relationship between researcher and participants,	Talking about abuse is an important step in a woman's process of change
3)R. Hussain and A. Khan. Women's perceptions and experiences of sexual violence in marital relationships and its effect on reproductive health. *Health Care for*	To explore Pakistani women's experiences & perceptions of sexual violence within marriage, population study, 3 focus groups; 5-6 women in each group, 30 women interviewed.	Unstructured free flowing interviews (90 min-3H)= purposive sampling for interviews, Focus group & in-depth interviews, snowball sampling, for the focus groups	Women viewed sexual violence on a continuum of physical & verbal abuse and that negotiation to have safe sex is difficult and could lead to unwanted pregnancy and sometimes abortions, clear ethical issues, did NOT	Focus on sexual violence, topic guides: questions on the role of women, their status in society, and contextual determents of violence, justified designs, Findings discussed in relation to research	Attention to the link between violence and women's health and the impact of sexual violence on maternal and child health. When examining women's reproductive health, it

Women International 29 (5):468-483, 2008.			discussed the relationship between researcher and participants	question & to other research-based literature, thematic analysis to develop themes	is imperative to include a focus on domestic violence and its link with the low status of women.
4)S. Ringel and R. Bina. Understanding causes of and responses to intimate partner violence in a Jewish Orthodox community: survivors' and leaders' perspectives. *Research on Social Work Practice* 2007 (2):-86, 2007.	Aimed to explore causes of IPV, the cultural and religious barriers to s eek help, 8 Jewish Orthodox women recruited via a DV organization and contacts with Orthodox community in US.	Open-ended interviews, Qs; are there barriers to Orthodox women seeking help?, what are the cultural and religious values that affect Orthodox community attitudes?, clear recruitment criteria, data analyzed using the constant comparison method of modified grounded theory, clear interview guide, Findings discussed in relation to research question & to other research-based literature,	Some rituals like the law of family purity (abstinence from sex for 2 weeks during menstruation & women have to immerse in a special pool of water for purification) create stress & husbands become violent. Shame, fear of divorce & denial are barriers to seeking help, did NOT discussed relationship between researcher and participants	Orthodox Jewish women only. Religious communities practice traditional gender roles and strict adherence to religious doctrine, and may be isolated from the external community because of their lifestyle.	A better model of service delivery to include the development of a value-based practice that would respect and be culturally sensitive to the community.
5)A. Raj and J. Silverman. Domestic violence help-seeking behaviors of South Asian battered women residing in the United States. *International review of victimology* 14 (1):2007-2170, 2007.	Aimed to assess domestic violence help-seeking behaviors among battered South Asian women residing in Greater Boston, 23 women	In-depth interviews, recruited via community outreach (fliers, snowball sampling, referrals), 12 open ended Qs, used grounded theory approach for analysis	Women described No help-seeking within the abusive relationships, but ask for help after deciding to separate from their partners because the batterers isolate them & prevent them to access social support, help from family & friends, didn't disclose to their primary care providers due to shame	Used quantitative & qualitative methods, only immigrants, , Findings discussed in relation to research question & to other research-based literature,	
6)A. Flinck, E. Paavilainen, and P. stedt-Kurki. Survival of intimate partner violence as experienced by women. *J Clinical Nursing* 2005 (3):-93,	Aimed to describe women's experiences of IPV, look at what support they received, And address women's experiences of factors that enhanced their	Loosely formulated Interviews, 7 women, analyzed using qualitative content analysis through inductive category development,	Five categories; women felt that violation of intimate boundaries in childhood was a factor related to predisposing them to IPV, women viewed themselves as sexual objects, survival was promoted by faith in God,	Clear recruitment and ethical issue, clear categories described, Findings discussed in relation to research question & to other research-based literature,	

2005.	survival. Finland,		family of origin, friends, and support from a good therapist.		
7)D. K. Kaye. Community perceptions and experiences of domestic violence and induced abortion in Wakiso district, Uganda. *Qualitative Health Research* 16 (8):1120-1128, 2006.	Aimed to explore the link between DV and induced abortion, Uganda,	12 focus groups, each 6-10, men & women + in-depth interviews. For in-depth interviews, participants interviewed were identified by theoretical sampling (purposeful sampling according to emerging findings from the focus groups), justified design	Misconceptions about contraception, e.g. it may cause uterine cancer, women were hiding the use of pills, men were reportedly anxious about their spouses' being employed, men viewed that induced abortion was unacceptable but economic hardship could affect women's decision	The focus group discussion & interviews guide explored issues related to contraception, cultural values, employment, domestic violence, and induced abortion, clear recruitments criteria, and ethical issue, clear categories described, Findings discussed in relation to research question & to other research-based literature,	To explore the role of gender in contextualizing reproductive health behaviour and to involve men in reproductive health, especially regarding contraceptive use.
8)Galvani. S. Alcohol and Domestic Violence: Women's Views. *VIOLENCE AGAINST WOMEN.*2006; 12: 641-662	Aimed to hear their views on the role of alcohol in men's violence to women, aimed to develop theory, grounded in the women's views, that offers an explanation for alcohol's role in the violence they experienced, UK, 20 women, lasted 75 min average, population-based study, aged 18-44	Grounded theory approach, in-depth semi-structured interviews, supplemented by VABI Questionnaire for triangulation purpose, focused on thematic saturation rather than on theory development,	Majority believed alcohol is not responsible for men' violence against women, and not enough good reason to forgive, clearly stated themes	Justified methods, discussed he relationship between the researcher and participant, clear recruitment criteria, details of ethical issue, findings discussed in relation to the original research question and research-based literature	Need to explore the issue of role of alcohol in IPV in a sensitive and careful manner

9)K. F. Lutz. Abuse experiences, perceptions, and associated decisions during the childbearing cycle. Western Journal of Nursing Research 27 (7):802-824, 2005.	Aimed to generate a theoretical understanding of women's experiences and perceptions of IPA during the childbearing cycle, included pregnant women with diverse ethnicity, Urban US area, recruited by referrals from health care providers at two prenatal clinics, other health professionals, distributed fliers, word of mouth, and study participants, health care setting	Snowball sampling, 12 women, in-depth interviews, used the grounded theory method of dimensional analysis. The DA explanatory matrix is a framework for the analytic processes of grounded theory research that is used to answer the question "What all is involved here?" (Schatzman, 1991, p. 310).	Disparities between the phenomena of IPA and pregnancy led a woman to feel as though she was living two different lives. Cultural, social, and religious values and expectations strongly influenced women's perceptions of the risks and costs of IPA. The sociocultural or religious group often conveyed sanctions against leaving a relationship, which underscores the importance of understanding a woman's socio-cultural background.	Interviews were conducted in two stages, clear themes, recruitment, and ethical issue. findings discussed in relation to the original research question and research-based literature	Recommended to screen for IPV and intervene could be conducted with mothers in paediatric settings because women's perception of an abusive relationship altered significantly after birth up to 2 years later.
10)K. F. Lutz. Abused pregnant women's interactions with health care providers during the childbearing year. *JOGNN - Journal of Obstetric, Gynecologic, & Neonatal Nursing* 34 (2):151-162, 2005.	Pregnant women, U.S, Participants were interviewed in their homes, at their prenatal clinic, at a hospital, and at the investigator's office.	Snowball sampling, 12 women, interviews, used the grounded theory method of dimensional analysis; The process of theoretical sampling was used (Strauss & Corbin, 1994). In theoretical sampling, data collection, coding, and analysis occur simultaneously. Through the process of theoretical sampling, the developing theory guided the direction of the inquiry and acquisition of subsequent Data.	The majority of participants did not disclose the IPA to their prenatal care provider. Women of color stressed the importance of health professionals understanding patients' socio-cultural context. Participants suggested that obstetric care providers inquire about how things are going at home in a general, conversational manner to establish a positive connection with the pregnant woman and provide an opportunity for her to share information about her private life.	Interviews were conducted with some women in two stages, clear categories, recruitment, and ethical issue. findings discussed in relation to the original research question and research-based literature	Health professionals have to recognise the dynamic nature of IPV and have a plan of care to respond to abuse disclosure. IPV education familiarises abused women about the resources and provides important validation and labelling of actions that they may not be able to identify as abusive.
11)Crandall, M., Senturia, K., Sullivan, M., & Shiu-Thorton, S.	24 Russian-speaking women, aged 19-61 years, in Seattle and	semi-structured interviews and focus group, justified design, clear recruitment criteria, clear	Women not aware of DV, keeping the family together is an important factor, women	Topics covered included the following: the cultural context of domestic	Immigrant women should be provided with information about

(2005). "No way out": Russian-speaking women's experiences with domestic violence. *Journal of Interpersonal Violence, 20*, 941-958.	King County, aimed to explore: (a) the cultural Experience of domestic violence among Russian-speaking women, (b) access to and satisfaction with domestic violence services among these women, and (c) survivor solutions for addressing domestic violence in their community, population-based study.	ethical issues, discussed results in relation to research question and to research-based literature, did Not discuss the relationship between researcher and participants,	developed strategies to combat the abuse, they were not aware of services for help	violence, including community definitions of domestic violence and abuse; awareness of domestic violence services, cultural factors affecting service utilization, and problems with service delivery; and recommendations for Helping victims and/or survivors experiencing domestic violence.	domestic violence resources in their language. To improve the bilingual and bicultural outreach, culturally appropriate domestic violence service provision.
12)Ruchira Tabassum Naveda, Safia Azimb, Abbas Bhuiyaa, Lars Ake Perssonc. Physical violence by husbands: Magnitude, disclosure and help-seeking behavior of women in Bangladesh. Social Science & Medicine 62 (2006) 2917–2929	Aims included identification of the forms of violence experienced and how women communicate their experiences population-based, Bangladesh, reproductive age women,	Part of a large survey, 28 women, purposive snowballing sampling, , clear recruitment,	Majority didn't inform anyone of their abuse, reasons; fear of jeopardizing family honor; stigma that will tarnish the woman's own reputation; securing their child's future; fear of repercussion from the husband; hopelessness; expectation that things would change; threat of murder; and belief that violence is the husband's right, some women chose to disclose if; severe physical abuse, threat of murder, and harm caused to children. Talk more to parents, siblings, no body ask institutional sources for help	+justify the design, enough details of ethical issue discussed the findings in relation to the original research question and to research-based literature, did NOT consider the relationship between researcher & participants	Providing only institutional support to help women living in violent relationships would not achieve desirable goals as only a very small proportion of women go to formal source for help. Hence, education and mass media are probably the two most powerful tools through which these changes can be achieved. Challenges directed at age-old values and norms seem essential for preventing domestic violence.
13)Rupaleem Bhuyan, Molly Mell, Kirsten Senturia, Marianne Sullivan and Sharyne	Asian Cambodian living in US, aimed to understand how women with different	39 women, aged 32-66, purposive sampling, focus groups,	Abuse regarded as a normal issue in Cambodian community, didn't report abuse, reasons; fear of partners, sake of family	Clear recruitment criteria, detailed ethical issues, somehow discussed the analysis process, discussed	Future studies should attempt to include greater number of women, first-and

Shiu-Thornton. "Women Must Endure According to Their Karma": Cambodian Immigrant Women Talk About Domestic violence. *J Interpers Violence* 2005; 20; 902.	sociocultural contexts interpret and respond to abuse, population-based,		and children, at odds with Khmer social values, women had limited awareness of available resources for help,	the findings in relation to the other original question and to research-base literature, did NOT consider the relationship between researcher & participants	second-generation immigrants, and women of varying socio-economic status to expand or expand or confirm the findings. To ask women whether they are aware of available violence help resources?
14)Bui. H. Help-Seeking Behavior Among Abused Immigrant Women: A Case of Vietnamese American Women. *VIOLENCE AGAINST WOMEN* 2003; 9; 207-239.	Aimed to understand factors associated with their decisions to seek help, population-based	In-depth interviews with 34 Vietnamese American women, snowballing technique, aged 20-58, semi-structured Qs for 2-3 H,	Women seek help from legal agencies, family and friends. However, shame and fear of the abuser prevented many women from disclosing their experiences of intimate violence. Seeking help depends on factors; economic dependency, cultural isolation, language barriers, and lack of understanding of the law	NO clear description of recruitment, No ethical issue mentioned, limited discussion of the findings in relation to the other original question and to research-base literature, did NOT consider the relationship between researcher & participants	Public policies and programs aimed at helping women escape abuse need to recognize various cultural, structural, and organizational forces that shape women's experiences of and responses to abuse to provide appropriate services. Additional studies on the experiences of help seeking among abused women from different immigrant groups are needed to improve generalizability.
15)Melanie Lutenbacher, Alison Cohen, and Julia Mitzel. Do We Really Help? Perspectives of Abused Women. *Public Health Nursing* Vol. 20, No.1,	Caucasian and African American, aimed to describe factors that inhibit, support, and sustain women's abilities to leave abusive relationships and to stay	Focus groups, 24 women aged 21-51 (mixed method survey), and semi-structured interviews,	The results here are for focus groups only, clear categories; Living unnatural experience, the experience of telling (fears of asking for help), the leaving experience (stress of life changes), reducing barriers	Clear ethical issues, NO justification of method, recruitments not clear, clear analysis description, discussed the findings in relation to the other original question and to	Recommendations are made to improve community interventions and programs that will facilitate the choice and enhance the success of

56–64	out of those relationships once they have left.		(education of potential health professionals, routine screening in health settings)	research-base literature, did NOT consider the relationship between researcher & participants	women who have experienced domestic violence.
16)Kulwicki, Anahid Devartanian, and Miller, June. (1999). Domestic Violence in the Arab American Population: Transforming Environmental Conditions through Community Education. *Issues in Mental Health Nursing*, 20 (3), 199-215.	Arab American, , population-based study, aimed to (a) assess the attitudes and behaviors toward domestic violence of 200 Arab individuals, (b) develop and implement a mass media campaign that provides relevant Arabic and English domestic violence educational materials to the project population community, and (c) develop a community-outreach campaign to educate community members regarding domestic violence.	Interviews using; The Husbands' Patriarchal Beliefs Questionnaire, conducted by Arabic speaking nurses. Sample; women; 162, men; 40, mean age 33 years.	Results: 58% of women and 59%ofmen approved of a man slapping his wife if she hits him in an argument, 4%of the respondents actually believed that a man should kill his wife if she hits him during an argument, and 48% of the women and 23% of the men approved of a man slapping his wife if he learned she had been unfaithful.	Results reported in a quantitative manner. Study was not focused mainly to explore Arab women' views and understanding of IPV, but was concerned to develop some form of preventive measure to educate the Arab American population.	Some Arab cultural values may prohibit or discourage women from seeking help from community resources. Recommendation: Although this project has been instrumental in identifying and providing support to women of this community, the education and support services must be continued and expanded to continue to seek changes in the environmental conditions that influence family violence.
17)Mona Bakry Abdel Meguid. Measuring Arab immigrant women's definition of marital violence: creating and validating an instrument for use in social work practice, dissertation. The Ohio State University 2006	Aimed to design a valid and reliable instrument to measure Arab immigrant women's perceptions of intimate partner violence. The instrument was designed to investigate how Arab immigrant women understand intimate partner violence,	224 Arab-Muslim women, self-reported questionnaire, 65 items/statements	Results showed that the length of stay Arab-Muslim women been in the United States and the amount of education they have received influence their perception of marital violence and their help-seeking preferences	Study aimed to develop a culturally specific questionnaire, not particularly exploring women's experiences of IPV.	The researcher recommends a qualitative method be used that gives participants the chance to express in their own words what defines marital violence. other studies could examine how battered women from an Arab-

	what help-seeking sources they consult in case of intimate partner violence, and what barriers they might perceive in seeking outside help.				Muslim background define help-seeking to incorporate actions that have not been considered here
18)Gene S.Feder, Madeleine Huston, Jean Ramsay, Ane R. Taket. Women Exposed to Intimate Partner Violence: Expectations and Experiences When They Encounter Health Care Professionals: A Meta-analysis of Qualitative Studies. *Arch Intern Med,* 2006; 166: 22-37.	Reported abused women's expectations and experiencesthe when they encounter health care professionals,	Qualitative studies of women aged 15 or more with experience of IPV, included 29 articles.	findings showed consistent emerging constructs across studies. The key constructs included that women wish nonjudgmental responses from health cre professionals, non-directive, and individually tailored, with an appreciation of the complexity of partner violence.	It is a summary of women experiences with health professionals not their experiences of the violence itself.	Future research on health care professionals' response to women with IPV should include longitudinal studies of women's experiences at different stages and qualitative studies in parallel with trials of health care-based interventions.
19)Martha R. Sleutel. WOMEN'S EXPERIENCES OF ABUSE: A REVIEW OF QUALITATIVE RESEARCH. Issues in Mental Health Nursing, 1998, 19:525-539.	Summarized the women experiences and views in order to identify themes from the women's owen stories and compared these themes across studies.	Did not mention number of studies included in the review, Women were from various cultures; North American, Black, Israel, included elderly women.	Battered women's accounts of their experiences in abusive relationships aid in understanding why they stay, how they cope, and how others can help. Many abused women have described their situation as similar to being in jail, or being a prisoner. Battered women used denial, minimizing and placating as methods of coping with their partner's violence. The battered women described overwhelming difficulty in leaving their violent relationships	Very comprehensive review that summarize all aspects that could be involved in IPV; psychological, social, economical, and political issues. the themes and descriptions of partner abuse in Nicaragua to be similar to studies from North America, Europe and other countries	Future research should also focus on minority, elderly, pregnant, and affluent subjects and members of other cultures, who are currently underrepresented in domestic violence research. Health care and political leaders must expand the scope of public education and screening to include all areas where women access health care or

					community services
20)Alice G, Yick. Meta-synthesis of qualitative findings on the role of spirituality and religiosity among culturally diverse domestic violence survivors. *Qualitative Health Research*, 2008, **18;** 1289-1306	To explore, extract, and synthesise themes from related qualitatives studies on the role of spirtuality and religiosity with cultuarlly diverse domestic violence survivors.	Sample size of original studies; 2 to 21 participants. Used the steps of meta-synthesis outlined by Noblit and Hare	Eight qualitative studies. Themes: strength and resilience women derive from their spiritual or religious beliefs to cope with IPV, tension stemming from their religion's definitions or standards of an ideal family or marriage and the reality of their abusive marriage, tension stemming from religious or spiritual definitions of gender role, expectations and reality of abuse, experiencing a spiritual vacuum where women lost a part of their self and their connection to God, reconstruction as part of the spiritual journey involving renewing, rebuilding, reaffirmation, reawakening, or rediscovery. Recovering the spirit and self that involved a soul searching appraisal of their beliefs about themselves. Reinterpretations of 'submission' and weaving these new definitions into their life. Forgiveness as a part the healing process. Giving back; in the process of being transformed by their histories and experiences with abuse, a new level of awareness, compassion, and care for other	Very rich and exciting to read. There was no discussion that includes limitations and strength of the review. ? single reviewer	Practitioners working with domestic violence victims and survivors might want to assess to what extent a woman's spirituality or religion is a conduit of strength, hope, and resilience. Hence faith communities need to collaborate so as to develop culturally competent best practices in working with domestic violence victims. Recommend continuing to explore how race, culture and ethnicity influence definitions of forgiveness.

			women with similar life situations was spawned		
21)Ursula Kelly. "What will happen if I tell you" Battered Latina women's experiences of health care. *CNJR* 2006, 38, **4**,78-95.	Aim to improve health-care providers' understanding of the health-care experiences of battered Latina women.	Design and implementation were guided by a feminist framework and the concept of marginalization. Purposeful sampling of 17 interviewed women (19-53 years), data analyzed using Van Manen's approach; interpretive phenomenological approach	Themes; fear (matched fears of abusers and fear of detection and disclosure to HCP), worry, and uncertainty. However, they wanted to be asked about and to receive help.	Unique culture perspectives of Latin women.	Recommend anticipation of enquiring about IPV in health settings. Education campaigns on violence to include information about the consequences of disclosure. There is an increasing diversity of the general population, so there is a need to have culturally competent care.
22)Aune Flinck, Eija Paavilainen, and Paivi Astedt-Kurki. Survival of intimate partner violence as experienced by women. *Journal of clinical nursing*, 2005, **14**, 383-393	Aims to descibe women's experiences of IPV, the consequences, the help they recieved and their experiences of their survival. Finland	Open ended interviews with 7 women. Analysis by inductive qualitative content analysis.	IPV occurred in situations of disagreement. Both couples believed as having weak identities, with different ideals, pattern of marriage and sexuality. Women sought help if their health and social relationships got worse. Factors helped them to survive were; awareness of the problem, counselling, and social relationships. Five categories emerged; Family with no security, family life behind the scenes, women's secrets, symptoms and signs, received support, and supporting factors.	Reporting Men's views, indirectly Via women? Small sample	Need of further research in different cultures and societies. Development of new care models on violence prevention. Both parties should be listened to in IPV. Future research could be focused on religious and cultural stereotypes and on beliefs and myths underlying sexuality. Enquire about childhood experiences.
23)Lois Magnussen, Jan Shoultz, Kay Hansen,	Aim; to examine cultural perceptions, awareness,	2 Focus groups (initial and validation), women age; 24-63	Themes; Perception & awareness;	Not all the members of the focus groups have been	Health care providers need to provide

Merina Sapolu, Mili Samifua. Intinate partner violence: perceptions of Samoan women. *Journal of community health,* 2008, **33,** 389-394.	responses, and actions recommended about IPV by Samoan women in community health center immigrant to Hawai'i.	years, content analysis	Identification of abuse, Causes of abuse, Family and community issues. Response to IPV; keeping the abuse as a secret, option for action and cultural responses Interventions; teaching the new generation and actions proposed.	exposed to PV	culturally sensitive care for abused women.
24)Kristie A. Thomas, Manish Joshi, Eve Wittenbrg and Laura A. McCloskey. Intersections of harm and health: a qualitative study of intimate partner violence in women's lives. *Violence Against Women,* 2008, **14 (11),** 1252-1273.	To elicit women's descriptions of how IPV affects their health, Philadelphia	8 focus groups of abused women	3 categories emerged; IPV leads to adverse health effects, IPV worsens already compromised health, and illness and disability increase dependency on abusive partners. Pathways linking IPV and health are bidirectional and cyclical	This study concepts are consistence with my theoretical framework	Further research to assess the violent-health interface. Both qualitative and quantitative methods are needed to illuminate the complex link between IPV and health
24)Muntaha Gharaibeh, and Arwa Oweis. Why do Jordanian women stay in an abusive relationship: implications for health and social well-being. *Journal of Nursing Scholarship,* 2009, **41(4),** 376-384.	To explore why Jordanian women stay with an abusive husband,	28 abused women, in-depth interviews, content analysis	Reasons for stay; the inherited social background (in terms of their broken and abusive families, and family not approving the ideal of leaving), financial dependency (low income with less education), lack of family support, sacrificing self for the sake of children, and the adverse social consequences of divorce (fear of stigma).	Similar to my population in terms of socio-cultural context, language, and religious beliefs.	Health care providers need to lobby politicians at the national level to institute policies that empower women educationally, socially, and financially Need of more qualitative research to explicate the consequences on the children of violence against women.
25)Nora Montalvo-Liendo, Dian W.	To descibe the factors that influence disclosure	26semi-structured interviews, grounded theory principles	Disclosure decision influenced by; socio-cultural role in	IPV and immigrant status render these women	Encouraging women to disclose and

Wardell, Joan Engebreston, and Belinda M. Reinginger. Factors influencing disclosure of abuse by women of Mexican Descent. *Journal of Nursing Scholarship,* 2009, **41(4),** 359-367.	of abuse by women from Mexican descen, immigrant to US.	guided the analysis,	preserving the family unity and fears of losing their children. Categories: kept behind closed doors (disclosure is restricted by being trapped at house), lying and denying (when asked by police, health care providers, and family, to protect children, fear of uncertainty and love their partners), compelled decision (crises situation that forced them to call police), unburdening decision (disclosure triggered by wanting someone to listen to them), validation (wanting to talk to someone for validation without being told what action they should take) and retraction (retracting their previous statement about abuse to the police).	vulnerable.	considering the cultural elements.

Appendix 5: focus groups guide

Saudi women's health status living in the UK

Focus group

Introduction

I am Samia Alhabib, doing a PhD in University of Bristol. My project will be about the health status of Saudi women living in the UK. I believe you have received a copy of the questionnaire, information sheet, and the consent form, and had the chance to try to answer the study questionnaire. During the discussion, you will be given your views on the wording, quality of translated language, layout and contents of the questionnaire. You would also be asked to comment on the documentation that will be sent with the questionnaire. The questionnaire and the accompanying paperwork will then be refined in light of the comments made. Today's focus group will be tape recorded and this is done so that we have a comprehensive record of all of the issues that we discuss today. I would like to assure everyone that all your responses are confidential. By this I mean that only the research team will see the transcriptions of the tape recordings and that when the final report of all the focus groups is written no one will be identified individually. Is everyone ok with that?

Ground rules

- There is no right or wrong answer.
- All views are equally valid.
- Ask people to speak one at a time if possible.
- I am here to facilitate the discussion and that I am happy for participants to question one another and discuss issues among themselves and not simply to me.
- Do not use each other names during the discussion.

Appendix 6: Focus groups' information sheet

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Information sheet B

Version 1, 30 May 2008

The Health of Saudi Women Living in the UK

Thank you for considering taking part in this research. This information sheet provides details about the study. Please take time to read it before deciding whether or not you would like to take part.

The aim of the study:

This research will be carried out by researchers at Bristol University and funded by the Saudi Cultural bureau. This study aims to assess the health of Saudi women living in the UK. In this study, health refers to physical and psychological aspects of women's well-being.

Saudi women living in the UK will be posted a questionnaire to complete and return to the researcher. The questionnaires will focus on your general health, well-being, and any experience of physical and/or psychological distress at some point in your life.

The aim of the discussion group

It is very important that women being sent the questionnaire find it acceptable, clear and understand the questions being asked. The purpose of the discussion group is to ensure that this happens.

If you took part in the discussion group, you would be asked to complete a questionnaire and then, during the discussion group, to give your views on its content and layout. You would also be asked to comment on the documentation that will be sent with the questionnaire. The questionnaire and the accompanying paperwork will then be refined in light of the comments made.

The group will be held at a time and place that is convenient to those taking part. The group discussion will last about 2 hours and will be audio-taped.

Why have I been chosen?

You have been asked to take part in a discussion group because you are a Saudi woman living in the UK for more than six months. The questionnaire is to be posted to Saudi women who have lived in the UK for more than six months.

Do I have to take part?

You do not have to take part in the group discussion. If you choose to take part, you can refuse to answer a question if you wish and can withdraw from the group at any time without giving a reason and your legal rights being affected.

Will my taking part in this study be kept confidential?

All the information collected will be treated as confidential and stored securely at Bristol University. The only people who will see the information you provide will be the researcher and her two supervisors.

What will happen to the results of the study?

Everyone who has taken part can ask to be posted a summary of the findings at the end of the study. Findings from the study will be written up for publication in scientific journals and presented at international conferences. No one will be able to identify any of the participants from the published findings. Once the study has ended, all information provided by those who have taken part will be destroyed.

What I have to do now?

If you are happy to take part in the group discussion, please sign the consent form attached.

Contact for further information:

If you would like to talk to the researcher, **Samia Alhabib**, please call her on telephone number **07827669067.** Samia speaks both English and Arabic.

Appendix7: Consent form

Title of project: Saudi women's Health Status living in the UK.

Name of Researcher: **Dr. Samia Alhabib**

I have read and understood the information sheet for (version 1, 30 April 2008) the above study. ☐

I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason, without my medical care or legal rights being affected. ☐

I understand that the researchers may look at relevant sections of my data collected during the study, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data. ☐

I agree to take part in the above study. ☐

Name of Participant: Name of person taking consent:

Date: Date:

Signature: Signature:

Appendix 8: Summary of the changes and decisions made to the whole questionnaire survey that resulted from the focus groups.

Suggested Changes	Decisions made	Source
General changes		
Should put spaces between sections.	Spaces put between sections to indicate more clearly that a section had ended.	Focus groups
Numbers should be in Arabic.	Numbers put in Arabic so that they are consistent with the Arabic wording	Focus groups
Short vowels marks must be used.	Short vowels added because without them a word may have a completely different meaning, e.g. followed me, could be translated in Arabic to; يتبعني. Without vowels marks, this could mean follow my orders, but with vowels marks, يتَبَعّني, it will give the right meaning, i.e. followed me in order to spy on me and know my movements.	Focus groups
Suggested alternative translated Arabic words, in most of the questions, which were slightly different from the initial translation, but they give a clear meaning.	Alternative Arabic words were made in many occasions, when consensus was reached between members of the focus groups, e.g. threw me, my initial translation was; دفعني, which means just push me. To make it more descriptive, groups suggested more elaborative words; طرحني أرضاً, which means push me until I felt down.	Focus groups
Instructions for sections or questions should be written in bold.	Instructions in sections and questions were written in bold in order to make it clear for the participants.	Focus groups
Pointed to a few Arabic spelling mistakes, and use of Arabic commas.	Spelling checked and commas were inserted.	Focus groups and expert panel
To lighten the shading of questions.	Shading was lightened, because it looks more convenient and clearer to the reader	Focus groups
Put the age in categories.	Ages were not put in categories, because we felt it would be better to treat age as a continuous variable.	Focus groups
Marital status question should married and	Not to change, because we need to consider the different marital status in relation to other variables in the analysis. Thus, the	Focus groups

married	choices stayed as; married, never married, and divorced.	
In Q31: Asking women if they agree to be interviewed with the principal researcher and where they will be given imbursements for taking part? The suggestion is to give vouchers instead of paying transportation.	Agreed to give vouchers, because of some logistic problem, as processing the payment to participants via the University and this might breach the confidentiality, especially that names and address should be handled to the University in order to complete the payment to participating women. In addition to the fact that we do not know where will be the interview held, because it will be determined by the interviewee.	Focus groups
To add the principle researcher's e-mail	E-mail was added, because some women feel shy about discussing sensitive issues over the telephone.	Focus groups
To reduce the choices when answering some questions.	Choices were not changed, because reducing them might affect the internal validity of the questionnaire.	Focus groups
Changes made to SF-36 Survey		
Use Kilometres instead of miles.	Miles were converted into kilometers but miles were stated in brackets, as some women may still think in terms of miles rather than kilometers.	Focus groups
Suggested to use time of walking than distance.	Distance was left unchanged, because changing to time would change the meaning of the original question.	Focus groups
Changes made to CAS		
To delete boy/girl friends in the first section of CAS	Alternative Arabic word was used that include whether women were married, engaged, or separated (partner=شريك), in light of respecting the Saudi cultural values and norms.	Expert panel and focus groups
To carefully select the Arabic meaning of partner.	Agreed on proper Arabic word. Other researchers used husband, but we used a word that explain intimate adult relationship (شريك) = partner, that does not necessarily imply the legality of the partnership status, but include all	Focus groups and expert panel

	possibilities of relationships without insulting the Saudi culture.	
To delete question 25, which asked about putting foreign objects in the vagina?	Q 25 was deleted, because it is not acceptable and deeply offensive in Saudi culture.	Focus groups and expert panel
Changes made to information sheet		
Not to mention the Embassy in the information sheet.	The word Embassy was removed, as we understand that some women may feel uncomfortable or even unsafe answering a questionnaire associated with the Embassy because we need women to feel safe and complete the questionnaire without fears. However we agreed to re-phrase it to Ethical committee.	Focus groups
To mention how generally the Saudi women population will benefit from this project in the information sheet, e.g. prevention or awareness programs.	General aims added, as suggested, in the information sheet, because this will encourage women to take part.	Focus groups

Appendix 9: Survey questionnaire in Arabic

بسم الله الرحمن الرحيم

ID Number:

Faculty of Medicine and Dentistry
Academic Unit of Primary Health Care
Bristol 25 Belgrave Road, BS8 2AA
Tel: 01173313817
Email: samia.alhabib@bristol.ac.uk

صحة المرأة السعودية المقيمة بالمملكة المتحدة البريطانية

الرجاء تعبئة الإستبيان التالي وأخذ الوقت الكافي لقراءة كل سؤال بتمعن. علماً بأنه لا يتطلب الأمر منك كتابة الإسم في الإستبيان. كل ما تصرحين به سيكون في غاية السرية. الرجاء قراءة المعلومات المرفقة قبل البدأ بالإجابة على الأسئلة. حاولي إجابة جميع الأسئلة بكل أمانة بقدر المستطاع. الرجاء وضع دائرة حول الإجابة المناسبة لك.

الرجاء إعادة الإستبيان كاملاً في الظرف المرفق في خلال أسبوعين.

وشكراً جزيلاً لك على تعاونك ومساهمتك في هذا البحث.

أ. الصحة العامة

الرجاء أجيبي على كل الأسئلة الموجوده في هذا الإستبيان. في حالة عدم وضوح أي سؤال، أرجو إختيار أقرب إجابه لمفهومك للسؤال.

أ (1) . بصورة عامة، كيف ترين حالتك الصحية؟

1. ممتازة	2. جيدة جدا	3 . جيدة	4. لا بأس بها	5. سيئة

أ (2) بصورة عامة كيف تقيمي حالتك الصحية الآن مقارنة بالعام الماضي ؟

1	أفضل بكثير مما كانت عليه قبل عام
2	أفضل نوعاً ما من العام الماضي
3	تقريباً على ما هي عليه
4	أسوء نوعاً ما من العام الماضي
5	أسوء بكثير مما كانت عليه قبل عام

تتعلق البنود التالية بالإنشطة التي يمكن أن تقومي بها خلال يومك العادي.

في الوقت الحالي، إلى أي مدى تُقيّدك حالتك الصحية:

أ (3). من ممارسة الأنشطة الشاقة مثل: الجري، حمل الأشياء الثقيلة أو مزاولة الأنشطة الرياضية المجهدة جداً؟

1. نعم تُقيدني كثيراً	2. نعم تُقيدني قليلاً	**3. لا تُقيدني أطلاقاً**

أ (4). من ممارسة الأنشطة متوسطة الجهد ، كتحريك الطاولة أو التنظيف باستخدام المكنسه الكهربائية او تنظيف حديقة المنزل و العنايه بها؟

1. نعم تُقيدني كثيراً	2. نعم تُقيدني قليلاً	3. لا تُقيدني أطلاقاً

أ (5). من حمل المشتريات من البقاله او السوق المركزي؟

1. نعم تُقيدني كثيراً	2. نعم تُقيدني قليلاً	3. لا تُقيدني أطلاقاً

أ (6). من صعود الدرج لعدة ادوار؟

1. نعم تُقيدني كثيراً	2. نعم تُقيدني قليلاً	3. لا تُقيدني أطلاقاً

أ (7). من صعود الدرج لدور واحد؟

1. نعم تُقيدني كثيراً	2. نعم تُقيدني قليلاً	3. لا تُقيدني أطلاقاً

أ (8). من الانحناء او الركوع او السجود؟

1. نعم تُقيدني كثيراً	2. نعم تُقيدني قليلاً	3. لا تُقيدني أطلاقاً

أ (9). من المشي لاكثر من كيلومتر ونصف؟

1. نعم تُقيدني كثيراً	2. نعم تُقيدني قليلاً	3. لا تُقيدني أطلاقاً

أ (10). من المشي لمسافة نصف كيلو متر؟

1. نعم تُقيدني كثيراً	2. نعم تُقيدني قليلاً	3. لا تُقيدني أطلاقاً

أ (11). من المشي لمسافة منة متر؟

1. نعم تُقيدني كثيراً	2. نعم تُقيدني قليلاً	3. لا تُقيدني أطلاقاً

أ (12). من الإستحمام او ارتداء الملابس بنفسك؟

1. نعم تُقيدني كثيراً	2. نعم تُقيدني قليلاً	3. لا تُقيدني أطلاقاً

ب. الصحة البدنية

تتعلق البنود التالية بالمشاكل التي يمكن ان تواجهِكِ خلال تأديتك لعملك او للأنشطة اليومية المعتادة نتيجة لحالتك الصحية البدنية.

خلال الاسابيع الاربعة الماضية, هل تسبب حالتك الصحية البدنية في:

	لا	نعم
ب (13). التقليل من الوقت الذي تقضينه في العمل او اي انشطة اخرى؟		
ب (14). التقليل من ما تودين انجازه من العمل او اي انشطة اخرى؟		
ب (15). عدم انجاز العمل او اي انشطة اخرى بالحرص المعتاد؟		
ب (16). ان تجد صعوبة في تأدية العمل أو أي أنشطة اخرى؟ (على سبيل المثال, احتجت إلى جهد اضافي لتأديتها)		

ج. الصحة النفسية

تتعلق البنود التالية بالمشاكل التي يمكن ان تواجهك خلال تأديتك لعملك أو الأنشطة اليومية المعتادة نتيجة لحالتك الصحية النفسية (مثلا الشعور بالإكتئاب او القلق)

خلال الاسابيع الاربعة الماضية , هل تسببت حالتك النفسية في:

	لا	نعم
ج (17). التقليل من الوقت الذي تقضينه في العمل او اي انشطة اخرى؟		
ج (18). التقليل من مما تودين انجازه من العمل او اي انشطة اخرى؟		
ج (19). عدم انجاز العمل او اي انشطة اخرى بالحرص المعتاد؟		

د (20). الصحة البدنية او النفسية

خلال الاسابيع الاربعة الماضية, الى اي مدى تعارضت صحتك البدنية اوالنفسية مع تأديتك لنشاطاتك الاجتماعية المعتادة مع عائلتك او اصدقائك او جيرانك او اي من المناسبات الاجتماعية الاخرى؟

1. لم يكن هناك اي تعارض اطلاقا	2. كان هناك تعارض قليل	3. كان هناك تعارض متوسط	4. كان هناك تعارض كبير	5. كان هناك تعارض كبير جدا

ه (21). **شدة الألم:** ماشدة الألم البدني الذي عانيت منه خلال الاسابيع الأربعة الماضية؟

1. لم يكن هناك اي ألم	2. كان هناك ألم خفيف جدا	3. كان هناك ألم خفيف	4. كان هناك ألم متوسط	5. كان هناك ألم شديد	6. كان هناك ألم شديد جدا

و (22). الى اي مدى أدى الالم البدني الى التعارض مع تأديتك لأعمالك المعتادة خلال الاسابيع الاربعة الماضية؟

1 . لم يكن هناك اي تعارض	2. كان هناك تعارض قليل جدا	3. كان هناك تعارض متوسط	4. كان هناك تعارض كبير	5. كان هناك تعارض كبير جدا

ما مدى صحة أو خطأ كل من العبارات التالية بالنسبة الى حالتك الصحية؟

	صحيحه بلا شك	صحيحه غالبا	لا أعلم	خطأ غالبا	خطأ بلا شك
23. يبدو انني أصاب بالمرض أسهل من الآخرين.					
24. حالتي الصحية مساوية لأي شخص أعرفه.					
25. أتوقع أن تسوء حالتي الصحية.					
26. حالتي الصحية ممتازه.					

27. خلال الأسابيع الأربعة الماضية، ما مقدار الوقت الذي تعارضت فيه صحتك الجسمية أو مشاكلك النفسية مع نشاطاتك الاجتماعية (مثل زيارة الاصدقاء والاقارب وغير ذلك)؟

1. كان التعارض في كل الاوقات	2. كان التعارض في معظم الاوقات	3. كان التعارض في بعض الاوقات	4. كان التعارض في قليل من الاوقات	5. لم يكن تعارض في اي وقت من الاوقات

الأسئلة التالية تتعلق بشعورك و سير الأمور معك خلال الأسابيع الأربعة الماضية، الرجاء إختيار إجابة واحدة لكل سؤال بحيث تكون هذه الإجابة الأقرب إلى الحاله التي تشعرين بها.

خلال الأسابيع الأربعة الماضية, كم من الوقت:

	في كل الأوقات	في معظم الأوقات	في كثير من الأوقات	في بعض الأوقات	في قليل من الأوقات	لم أشعر في أي وقت من الأوقات
28. شعرت بأنك مليئة بالحيوية والنشاط؟	1	2	3	4	5	6
29. كنت انسانةً عصبية جدا؟	1	2	3	4	5	6
30. شعرت بأنك في حالة إحباط لدرجة أنه كان من الستحيل إدخال السرور إليك؟	1	2	3	4	5	6
31. شعرت بالهدوء والطمأنينة؟	1	2	3	4	5	6
32. كانت لديك طاقة كبيرة؟	1	2	3	4	5	6
33. شعرت بالحزن واليأس؟	1	2	3	4	5	6
34. شعرت بأنك منهكة (أُستنفذت قواك)؟	1	2	3	4	5	6
35. شعرت بأنك إنسانة سعيدة؟	1	2	3	4	5	6
36. شعرت بأنك متعبة؟	1	2	3	4	5	6

ز. العلاقات الزوجية و الصحة العامة

هذا الجزء يستفسر عن تجربتك في علاقتك العاطفية أو الحميمة. ونعني بذلك علاقتك الزوجية حالياً أو في أي وقت مضى, بشرط أن لا تقل مدتها عن شهر. الرجاء وضع دائرة حول الإجابة المناسبة لك.

ز1. هل سبق لك ان كنت في علاقة زوجية او عاطفية؟ (منذ بلغت سن الثامنة عشرمن العمر)

نعم.....1 إذا كان الجواب بنعم الرجاء إجابة السؤال الذي يليه

لا.....2 إذا كان الجواب بلا الرجاء الإنتقال الى السؤال رقم30 وبقية الأسئلة التي تليه

ز2. هل انت الان مرتبطة بعلاقة زوجية

نعم.....1

لا.....2 إذا كان الجواب بلا الرجاء الإنتقال الى السؤال30 وبقية الأسئلة التي تليه

ز3. هل انت حاليا خائفة من شريكك؟

نعم..... 1

لا.....2

ز4. هل سبق ان خفت من شريكك ؟

نعم.....1

لا.....2

نود الان معرفة اذا كنت تعرضت لإي تصرف من التصرفات التالية وكم مرة حدثت لك خلال السنة الماضية. وفي حالة لم يسبق لك ان كنت في إرتباط خلال السنة الماضية, الرجاء إجابة الأسئلة عن اي إرتباط سابق في اي وقت مضى.

الرجاء وضع دائرة حول الرقم الذي يناسب عدد مرات ما حدث لك خلال السنة الماضية.

كم مرة حدث لك؟

التصرف	لم يحدث اطلاقا	مرة واحدة فقط	عدة مرات	مرة في الشهر	مرة في الاسبوع	في كل يوم
1. قال لي انني لم اكن جيدة بدرجة كافية	0	1	2	3	4	5
2. منعني من طلب الرعاية الصحية	0	1	2	3	4	5
3. يَتَبَعني	0	1	2	3	4	5
4. حاول ان يقلب عائلتي و اصدقائي و اطفالي ضدي	0	1	2	3	4	5
5. حبسني في غرفة النوم	0	1	2	3	4	5
6.صفعني	0	1	2	3	4	5
7. إغتصبني	0	1	2	3	4	5
8. قال انني قبيحة	0	1	2	3	4	5
9. حاول ان يمنعني من رؤية عائلتي او التحدث اليهم	0	1	2	3	4	5
10. طرحني أرضاً	0	1	2	3	4	5

كم مرة حدث لك؟

التصرف	لم يحدث اطلاقا	مرة واحدة فقط	عدت مرات	مرة في الشهر	مرة في الاسبوع	في كل يوم
11. يتلصص حول بيتي	0	1	2	3	4	5
12. يلوميني بأنني سبب لتصرفاته العنيفة	0	1	2	3	4	5
13. هددني اثناء مكالمة هاتفية	0	1	2	3	4	5
14. هزني بعنف	0	1	2	3	4	5
15. حاول أن يغتصبني	0	1	2	3	4	5
16. هددني اثناء وقت عملي	0	1	2	3	4	5
17. دفعني, امسك بي بقوة	0	1	2	3	4	5
18. استعمل السكين, او المسدس او اي سلاح اخر	0	1	2	3	4	5

كم مرة حدث لك؟

التصرف	لم يحدث اطلاقا	مرة واحدة فقط	عدت مرات	مرة في الشهر	مرة في الاسبوع	في كل يوم
19. قال اني مجنونة	0	1	2	3	4	5
20. قال لي لن يقبل بك احد	0	1	2	3	4	5
21. اخذ محفظتي وتركني بلا شيء	0	1	2	3	4	5
22. ضربني او حاول ان يضربني بشيء ما	0	1	2	3	4	5
23. لا يرُيدني ان اجتمع مع صديقاتي	0	1	2	3	4	5
24. رفض ان اعمل خارج البيت	0	1	2	3	4	5
25. ينزعج إذا لم يجهز العشاء او تُنجز اعمال البيت كما يجب	0	1	2	3	4	5
26. رفسني او عضني او ضربني بقبضة يدة	0	1	2	3	4	5

كم مرة حدث لك؟

التصرف	لم يحدث اطلاقا	مرة واحدة فقط	عدت مرات	مرة في الشهر	مرة في الاسبوع	في كل يوم
27. حاول ان يقنع صديقاتي, عائلتي او اطفالي بأنني كنت مجنونة	0	1	2	3	4	5
28. قال لي اني غبية	0	1	2	3	4	5
29. ينهال علي ضرباً	0	1	2	3	4	5

أ. أسئلة عامة

العمر:

الحالية الإجتماعية: 1. متزوجة 2. غير متزوجة

مدة سنوات الزواج:

عدد الأولاد:

عدد سنوات الإقامة في بريطانيا:

المستوى التعليمي لك: 1. دراسات عليا 2. باكالوريس 3. ثانوي 4. متوسط
5 . إبتدائي 6. غير متعلم

المستوى التعليمي للزوج: 1. دراسات عليا 2. باكالوريس 3. ثانوي 4. متوسط
5 . إبتدائي 6. غير متعلم

نشكرك كثيراً على إجابة الأسئلة السابقة ونود أن نوضح أن هذا البحث يتطلب إجراء مقابلات شخصية للإستفسار عن بعض الأمور الصحية والنفسية التي لم يسمح بها هذا الإستبيان , لمن ترغب بذلك الرجاء وضع دائراة حول السؤال 30

30. هل من الممكن ان نجري لقاء معك في وقت لاحق علما بأنة ستمنح كل مشتركة كوبون مقداره عشرة باوند.

نعم.....1

لا.....2

شكرا لك على المشاركة في هذا الإستبيان. وعند الحاجة إلى أي مساعدة, بإمكانك الإتصال على مدار 24 ساعة بالأرقام:

247 2000 0808 :في انجلترا, في ويلز: 800 10 80 0808.

هذا سيوفر لك الوصول إلى خدمات اسعافية و إعطائك معلومات للتصرف بطريقة أمنه مع امكانية وجود المعلومات باللغة العربية. المكالمات من الخط الثابت لن تظهر في فاتورة الهاتف. وبالإمكان ايضا الاتصال بالرقم المباشر للخدمات الصحية على مدار الساعة: 08454647 او الاتصال بطبيبك مباشرة لطلب المساعدة. أو بالاتصال بالدكتورة سامية الحبيب على الرقم التالي: **07827669067** أو بإستعمال البريد الإلكتروني:

Samia.alhabib@bristol.ac.uk

Appendix10: Survey questionnaire in English

ID Number:

Faculty of Medicine and Dentistry
Academic Unit of Primary Health Care
Bristol 25 Belgrave Road, BS8 2AA
Tel: 01173313817
Email: samia.alhabib@bristol.ac.uk

The Health of Saudi Women Living in the UK

Please complete this questionnaire and take the time to read each question carefully. Please read the information sheet provided before commencing to answer the questions. Try to answer all the questions as honestly as you can. Please ***circle*** the answer that is best for you. There is no need to write your name on the questionnaire. Everything you say will be treated as confidential.

Please return the completed questionnaire in the pre-paid envelope provided within 2 weeks.

With many thanks for your contribution.

General Health and well-being

This section asks about your general health. Please answer all the questions. If unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first response. Please ***circle*** the answer that is best for you.

A1. In general, would you say your health is?

1. Excellent	2.Very good	3. Good	4. Fair	5.Poor

A2. Compared to one year ago, how would you rate your health in general **now**?

1	Much better now than one year ago
2	Somewhat better now than one year ago
3	About the same
4	Somewhat worse now than one year ago
5	Much worse now than one year ago

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

A3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports

1. Yes, limited a lot	**2.** Yes, limited a little	**3.** No, not limited at all

A4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

1. Yes, limited a lot	**2.** Yes, limited a little	**3.** No, not limited at all

A5. Lifting or carrying groceries

1. Yes, limited a lot	**2.** Yes, limited a little	**3.** No, not limited at all

A6. Climbing **several** flights of stairs

1. Yes, limited a lot	**2.** Yes, limited a little	**3.** No, not limited at all

A7. Climbing **one** flight of stairs

1. Yes, limited a lot	**2.** Yes, limited a little	**3.** No, not limited at all

A8. Bending, kneeling, or stooping

1. Yes, limited a lot	**2.** Yes, limited a little	**3.** No, not limited at all

A9. Walking more than a mile

1. Yes, limited a lot	**2.** Yes, limited a little	**3.** No, not limited at all

A10. Walking several blocks

1. Yes, limited a lot	**2.** Yes, limited a little	**3.** No, not limited at all

A11. Walking one block

1. Yes, limited a lot	**2.** Yes, limited a little	**3.** No, not limited at all

A12. Bathing or dressing yourself

1. Yes, limited a lot	**2.** Yes, limited a little	**3.** No, not limited at all

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	Yes	No
A13. Cut down the amount of time you spent on work or other activities	1	2
A14. Accomplished less than you would like	1	2

A15. Were limited in the **kind** of work or other activities	1	2
A16. Had **difficulty** performing the work or other activities (for example, it took extra effort)	1	2

During the **past 4 weeks,** have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	Yes	No
A17. Cut down the **amount of time** you spent on work or other activities	1	2
A18. Accomplished less than you would like	1	2
A19. Didn't do work or other activities as **carefully** as usual	1	2

A20. During the **past 4 weeks,** to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

1. Not at all	**2.** Slightly	**3.** Moderately	**4.** Quite a bit	**5.** Extremely

A21. How much **bodily** pain have you had during the **past 4 weeks**?

1. None	2. Very mild	3. Mild	4. Moderate	5.Severe	6.Very severe

A22. During the **past 4 weeks,** how much did **pain** interfere with your normal work (including both work outside the home and housework)?

1. Not at all	**2.**A little bit	**3.** Moderately	**4.** Quite a bit	**5.** Extremely

How TRUE or FALSE is ***each*** of the following statements for you.

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
A23. I seem to get sick a little easier than other people	1	2	3	4	5
A24. I am as healthy as anybody I know	1	2	3	4	5
A25. I expect my health to get worse	1	2	3	4	5
A26. My health is excellent	1	2	3	4	5

A27. During the **past 4 weeks,** how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

1. All of the time	**2.** Most of the time	**3.** Some of the time	**4.** A little of the time	**5.** None of the time

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks** . . .

	All of the time	Most of the time	A good bit of the time	Some of the time	A Little of the Time	None of the Time
A28. Did you feel full of pep?	1	2	3	4	5	6
A29. Have you been a very nervous person?	1	2	3	4	5	6
A30. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
A31. Have you felt calm and peaceful?	1	2	3	4	5	6
A32. Did you have a lot of energy?	1	2	3	4	5	6
A33. Have you felt downhearted and blue?	1	2	3	4	5	6
A34. Did you feel worn out	1	2	3	4	5	6
A35. Have you been a happy person?	1	2	3	4	5	6
A36. Did you feel tired?	1	2	3	4	5	6

B. Domestic relationships and well-being

This section asks about your experiences in adult intimate relationships. By adult intimate relationship, we mean a husband, partner or boy/girlfriend for longer than one month. Please circle the answer that is best for you.

B1. Have you ever been in an adult intimate relationship?

(Since you were 16 years of age) Yes.....1 ***Go to question B2***

No.....2 if ***no please go to the end of questionnaire***

B2. Are you currently in a relationship? Yes.....1

No.....2 ***Go to question B4***

B3. Are you currently afraid of your partner? Yes.....1

No.....2

B4. Have you ever been afraid of any partner? Yes.....1

No.....2

We would like to know if you experienced any of the actions listed below and how often it happened during the past 12 months. If you were not with a partner in the past 12 months, could you please answer for the last partner that you had? Please circle the number, which matches the frequency over a 12-month period that it happened to you.

How often it happened?

Action	Never	Only Once	Several Times	Once/ Month	Once/ Week	Daily
20. Told me that I was crazy	0	1	2	3	4	5
21. Told me that no one would ever want me	0	1	2	3	4	5
22. Took my wallet and left me stranded	0	1	2	3	4	5
23. Hit or tried to hit me with something	0	1	2	3	4	5
24. Did not want me to socialize with my female friends	0	1	2	3	4	5
25. Refused to let me work outside the home	0	1	2	3	4	5

26. Kicked me, bit me or hit me with a fist	0	1	2	3	4	5

How often it happened

Action	Never	Only Once	Several Times	Once/ Month	Once/ Week	Daily
11. Hung around outside my house	0	1	2	3	4	5
12. Blamed me for causing their violent behaviour	0	1	2	3	4	5
13. Harassed me over the telephone	0	1	2	3	4	5
14. Shook me	0	1	2	3	4	5
15. Tried to rape me	0	1	2	3	4	5
16. Harassed me at work	0	1	2	3	4	5
17. Pushed, grabbed or shoved me	0	1	2	3	4	5
18. Used a knife or gun or other weapon	0	1	2	3	4	5
19. Became upset if dinner/housework wasn't done when they thought it should be	0	1	2	3	4	5

How often it happened?

Action	Never	Only Once	Several Times	Once/ Month	Once/ Week	Daily
20. Told me that I was crazy	0	1	2	3	4	5
21. Told me that no one would ever want me	0	1	2	3	4	5
22. Took my wallet and left me stranded	0	1	2	3	4	5
23. Hit or tried to hit me with something	0	1	2	3	4	5
24. Did not want me to socialize with my female friends	0	1	2	3	4	5

25. Refused to let me work outside the home	0	1	2	3	4	5
26. Kicked me, bit me or hit me with a fist	0	1	2	3	4	5

How often it happened?

Action	Never	Only Once	Several Times	Once/ Month	Once/ Week	Daily
27. Tried to convince my friends, family or children that I was crazy	0	1	2	3	4	5
28. Told me that I was stupid	0	1	2	3	4	5
29. Beat me up	0	1	2	3	4	5

General questions

Please give your age:

Please give number of children:

Please give number of years living in UK:

Please circle your marital status: 1. Married.

2. Un-married.

If you circle one in previous question, please give us how many years you have been married:

Educational level of husband:

1. Postgraduate 2. University degree 3. Completed High school
4. Secondary school 5. Primary school 6. Illiterate

Your educational level:

1. Postgraduate 2. University degree 3. Completed High school
4. Secondary school 5. Primary school 6. Illiterate

30. Thank you for the time to answer this questionnaire. My research also entails interviews of some women to clarify issues in more detail. Women will be paid a

£10 voucher for their contribution to the interview. Therefore, would you be happy to be contacted about taking part in an interview?

Yes.....1

No.....2

Thank you for completing this questionnaire. If you need further help, you can call a free 24-hour national helpline in England: **0808 2000 247**, Welsh 24 Help-line: **0808 80 10 800.** This will provide access to 24-hour emergency information service, including safety planning and translation facilities. Calls from landlines will not appear on the telephone bill. You can call also the NHS direct: **08454647** or contact your GP for further help. You can also call Dr. Samia Alhabib on telephone **07827669067,** or e-mail her using the following e-mail: Samia.alhabib@bristol.ac.uk.

Appendix 11: Information sheet for survey participants

Faculty of Medicine and Dentistry
Academic Unit of Primary Health Care
Bristol 25 Belgrave Road, BS8 2AA
Tel: 01173313817
Email: samia.alhabib@bristol.ac.uk

Information sheet A

Version 1, 30 May 2008

The Health of Saudi Women Living in the UK

Thank you for considering taking part in this research. This information sheet provides details of the study. Please take time to read it before deciding whether or not you would like to take part.

The aim of the study

This study aims to assess the health of Saudi women living in the UK. It is being carried out by researchers at the University of Bristol and funded by the Saudi Cultural bureau. We are asking women to complete a questionnaire. The questionnaire asks women about their general health, well-being, and any experience of physical and/or psychological distress at some point in their life. At the end of the questionnaire, women are asked whether or not they would be willing to take part in an interview. A group of women who have completed the questionnaire will be interviewed so that some of the areas covered in the questionnaire can be discussed in detail.

Why have I been chosen?

You have been asked to take part in this study because you are a Saudi woman who has lived in the UK for more than six months. The Saudi Embassy recently telephoned you about this study and asked if you would be willing to receive a questionnaire. As you agreed to this, we are now posting you a questionnaire and further details about the study. In total, we hope to receive 800 questionnaires completed by Saudi women living in the UK.

Do I have to take part?

You do not have to take part in this study. If you choose to take part, you can decline to answer a question if you wish and can withdraw from the study any time without giving a reason and your legal rights being affected.

What will happen if I take part?

If you agree to take part, you will be asked to complete a questionnaire and return it to the researcher using a pre-paid envelope provided. At the end of the questionnaire, you will be asked whether or not you would be willing to take part in an interview. If you indicate that you are willing to be interviewed, the researcher may then contact you by telephone, to discuss the interview further and to arrange an interview time and place that suits you. You would be interviewed by the principal researcher, Samia Alhabib, and the interview would last about an hour. With your consent, it would be audio-taped, so that it can then be typed up for analysis. As we only need to talk to about 20 women, Samia will not need to contact everyone who indicates that they are willing to be interviewed.

Will my taking part in this study be kept confidential?

All the information collected will be treated as confidential and stored securely at Bristol University. The only people who will see the information you provide will be the researcher and her two supervisors. No individual names will appear in any publication or report of the study findings.

What will happen to the results of the study?

Everyone who has taken part in the study can ask to be posted a summary of the findings at the end of the study. Findings from the study will be written up for publication in scientific journals and presented at international conferences. No one will be able to identify any of the participants from the findings.

What I have to do now?

If you are happy to take part in this study, please complete the enclosed questionnaire and return it using the pre-paid addressed envelope provided. If you do not want to take part, please complete and return the postcard.

Contact for further information:

If you would like to talk to the researcher, **Samia Alhabib**, please call her on telephone number **07827669067.** Samia speaks both English and Arabic. You can call also the NHS direct: 08454647 or contact your GP for further help.

Appendix 12: relationships between IPV and socio-demographic profiles using Chi-square test

Socio-demographic profiles	**Severe combined abuse**				**Emotional abuse and/or harassment**			
	Yes	No	Total	P-value	Yes	No	Total	P-value
No. of children: <3	13 (16.5%)	66 (83.5%)	79 (100%)	0.1	12 (15.2%)	67 (84.8%)	79 (100%)	0.06
≥3	17 (21%)	64 (79%)	81 (100%)		5 (6.2%)	76 (93.8%)	81 (100%)	
Participants' age: 18-30	11 (17.5%)	52 (82.6%)	63(100%)	0.5	4 (6.4%)	59 (93.6%)	63 (100%)	0.07
31-60	10 (16.7%)	50 (83.3%)	60 (100%)		10 (16.7%)	50 (83.3%)	60 (100%)	
Women's education:								
*Postgraduate	16 (16.5%)	81 (83.5%)	97 (100%)	<0.01	11 (11.3%)	86 (88.7%)	97 (100%)	0.9
*Bachelor	6 (13%)	40 (87%)	46 (100%)		5 (10.9%)	41 (89.1%)	46 (100%)	
*≤High school	8 (61.5%)	5 (38.5%)	13 (100%)		1 (7.7%)	12 (92.3%)	13 (100%)	
Partners' education:								
*Postgraduate	9 (13.9)	56 (86.2%)	65 (100%)	<0.01	7(10.8%)	58 (89.2%)	65 (100%)	0.7
*Bachelor	11 (22.9)	37 (77.1%)	48 (100%)		8 (16.7%)	40 (83.3%)	48 (100%)	
*≤High school	9 ((56.2%)	7 (43.8)	16 (100%)		2 (12.5%)	14 (87.5%)	16 (100%)	
Length of marriage/years:								
*0-9	10 (15.4%)	55 (84.6%)	65 (100%)		7 (10.8%)	58 (89.2%)	65 (100%)	0.8
*10-19	12 (27.3%)	32 (72.7%)	44 (100%)	0.2	9 (20.5%)	35 (79.5%)	44 (100%)	
*20-32	6 (30%)	14 (70%)	20 (100%)		1 (5%)	19 (95%)	20 (100%)	
Length of stay in the UK/years:								
*0-1.9	13 (24.5%)	40 (75.5%)	53 (100%)	0.7	5 (9.4%)	48 (90.6%)	53 (100%)	0.5
*2-4.9	7 (12.1%)	51 (87.9%)	58 (100%)		8 (13.8%)	50 (86.2%)	58 (100%)	
*5-45	5 (20%)	20 (80%)	25 (100%)		4 (16%)	21 (84%)	25 (100%)	
Women' fears of partners:								
*Yes	13 (72.2%)	5 (27.8%)	18 (100%)	<0.01	2 (11.1%)	16 (88.9%)	18 (100%)	0.7
*No	14 (14%)	86 (86%)	100 (100%)		15 (15%)	85 (85%)	100 (100%)	

Appendix 13: relationship between IPV and SF-36 scores using Chi-square test

SF-36 Items	Severe combined abuse			Emotional abuse and/or harassment		
	Yes (mean score & 95% CI)	No (mean score & 95% CI)	P	Yes (mean score & 95% CI)	No (mean score& 95% CI)	P
Physical functioning	30 (77.7, CI=70.9-84.6)	128(86.5, CI=83.6-89.4))	*<0.01*	17 (87.4, CI=77.5-87.2)	141 (84.5, CI=81.7-87.4)	0.5
Role limitations due to physical health	30 (48.3, CI=35.2-63.4)	128 (78.7, CI=72.8-84.6)	*<0.01*	17 (67.6, CI=50-85)	140 (73.6-79.8)	0.5
Role limitations due to emotional problems	30 (31, CI=17.3-45)	127 (57, CI=49.4-64.6)	*<0.01*	17 (39.2, CI=16.4-62.1)	140 (53, CI=46.4-60.8)	0.2
Emotional well-being	30 (47, CI=38.4-55.8)	128 (65, CI=61.7-68)	*<0.01*	17 (54.6, CI=45.4-63.8)	141 (62.3, CI=58.9-65.8)	0.1
Social functioning	30 (56.3, CI=45.5-67)	127 (72.5, CI=68.4-76.7)	*<0.01*	17 (66.9, CI=56.5-77.3)	140 (69.7, CI=65.4-74)	0.7
Pain	30 (56.4, CI=46.6-66.2)	128 (75, CI=71-78.9)	*<0.01*	17 (66, CI=54.4-77.7)	141 (72, CI=68-76)	0.3
Energy/fatigue	30 (39.8, CI=33.8-45.8)	128 (52.9, CI=49.6-56.3)	*<0.01*	17 (45.6, CI=38.7-52.5)	141 (51, CI=47.7-54.3)	0.3
General health	30 (56.7, CI=51.5-63.8)	128 (69.9, CI=67.2-72.5)	*<0.01*	17 (66.5, CI=58.3-74.8)	141 (67.7, CI=65-70.4)	0.8

Appendix 14; Interviews topic guide

Background

Tell me a bit about yourself, for example, where you were born, who you live with, your age, family and how many children you have and their ages, do you work?

Tell me about your partner

His age, family, job, interests, personality

Tell me about your relationship with your partner:

How did you meet

How old were you both when you first met

When did you get married

Where have you lived

Women's experiences of domestic violence

Tell me how your relationship with your husband has developed/changed over the years?

How did you feel when you were first married? What was your relationship like? What is it like now? Prompt for possible reasons for any changes.

Do you and your partner ever argue or get upset with each other?

When did you start to argue?

How far do these conflicts go?

Can you remember what happened the first time you had an argument?

Prompt for verbal, physical and sexual abuse

How it started?

How did you react? What did you do (help seeking)

What impact did it have on you? Prompt for impact on physical, mental and social wellbeing, views of self, relationship with and view of partner, ability to function and work

Did anyone know about this abuse? Children, family, friends? If so, how did they find out? How did they react? If not, how did they not know? Why did you not tell them?

When was the next episode of abuse?

What has happened since?

What is the pattern now? Prompt for frequency, predictability, nature of abuse, reasons for abuse, and how she responds

Do you think there is any reason for this pattern? Prompt-frequency and severity

Help seeking behaviours

I have asked you a bit about how you have reacted when you have been abused but I would now like to ask some more specific questions:

After an argument/abuse, what do you usually do? Prompt in relation to talking to others, talking to partner, phoning helpline, contacting GP, seeking medical help

If she has sought help, ask why she told those people/used that particular service, *if not, ask why not*?

If she only seeks help sometimes, ask why she sought help on those occasions and not others?

What help and support are you wanting?

What help have you received?

Have you ever needed a medical assistance? If so, what type and why? If not, why not?

Effect of abuse on women

How do you currently feel about yourself and your partner? Prompt for afraid of partner, love partner

How is your current health and how has abuse affected it? Prompt-physical, emotional and social impact

What else has affected your health and ability to do daily work?

What about your children? Do they know about the abuse? If so, how did they found out? How do you think it has affected them? Has your partner ever hurt them?

Beliefs as to why women do not always leave the men who beat them

Why do you think some women do not leave their partner who abuses them?

What other factors you do think women consider before deciding to leave their partner?

Why do you stay with your partner?

What other possibilities have you thought about?

What do you see as abuse or not?

Do you see these acts as abuse?

Role of religion, culture and social values in the dynamic of IPV

Do you think Islam as a religion plays a role in the occurrence of IPV?

How religion, culture, or social values help you to tolerate or refuse violent behaviour from your partner?

Which one most effects your decision to stay or leave your partner; religion, culture, or social values of your family?

Women's perception of domestic violence as a private vs. public concern

What do you see/define as abuse? What types of behaviour? [provide some physical and emotional examples from the CAS

Do you think that domestic violence is a private matter or should we involve outside help like police or health professionals?

Who do you think need to be involved to discuss and/or help the women who have been abused?

What do you think would help women in your situation?

Is there anything you want to say about this study, your situation and domestic abuse in general?

Thank you for your time

Reassure about confidentiality

Appendix 15: Out of office research interviews: Contact details and call-in form

1 copy to base contact

1 copy with researcher

Researcher's name	
Researcher's mobile telephone number	
Interviewee's name, address, home telephone number	To be supplied in a sealed envelope with interview number written on the front.
Name and phone number of base-contact	

Interview	BOX A	BOX B	BOX C	BOX D
Date & time of visit	Time that researcher will call to base-contact after the interview	Base-contact sign here to show that researcher is safe	Time that base-contact should call researcher if BOX B not completed	Time that base-contact should call police if BOX B not completed
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

Instructions to base contact:

1) If researcher does not call to report safe, then at time in **BOX C** call the researcher in their mobile phone number.

2) If no response, open the relevant envelope and call them at the interviewee's phone number (their mobile phone may not have a signal)

3) If no response, at time in BOX D, stay calm and do the following:

Call 999

Explain the situation calmly to the police

Give the police:
YOUR NAME
YOUR PHONE NUMBER
RESEARCHER'S NAME
RESEARCHER'S MOBILE PHONE NUMBER
INTERVIEWEE'S ADDRESS
INTERVIEWEE'S PHONE NUMBER
BRIEF EXPLANATION OF THE STUDY
EXPECTED TIME OF INTERVIEW ENDING

Ask the police to visit the interviewee's home to check that the researcher is alright

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